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THE DIAGNOSIS OF PREGNANCY.

CLINICAL LECTURE BY E. E. MONTGOMERY, M. D.,

Professor of Gynæcology, Jefferson Medical College; Obstetrician to Philadelphia Hospital; Gynæcologist to St. Joseph's Hospital.

Gentlemen:—Since last we met together in this room, the old amphitheatre, which lingers in the memories of men who are scattered throughout every section of the world, has given place to a new building. In the old amphitheatre students have listened to such men as Gross, Pancoast and Agnew in surgery, to Stille, DaCosta, Pepper and others equally distinguished in medicine, and necessarily about its walls must cling very tender and pleasant memories. But to-day we enter a new room; one that is arranged with all the ideas of modern medicine and surgery, one that is equipped with the greatest comfort for you, ladies and gentlemen, and affords the best opportunities for succesful clinical work. I was asked yesterday by the Board of Charities to request you to co operate with them in keeping this room in a handsome condition, and from what I know of medical students, I feel satisfied that it is only necessary for me to speak to you of their wishes to secure your earnest co-operation. I am sure you will join with me in congratulation and earnest thanks to the Board of Charities for so excellent and well-equipped a room, one which is unexcelled by any other hospital in this country.

*Delivered at the Philadelphia Hospital, October 1st, 1892.

The first patient I bring before you is a woman seventeen years of age, both of whose parents are dead, her mother having died of phthisis, the father from some cause unknown. She has lost two brothers, three are living, and all her sisters. She herself has suffered from whooping-cough, malaria, and the ordinary diseases of childhood. Menstruation appeared at the fifteenth year, was at once regular, occurring every four weeks and lasting from two to four days. She has never had any venereal disease. Her menses appeared last on the fifth of March. Since that time she has noticed that the abdomen has increased in size, beginning at the lower part, and has occurred without any pain or distress, with no vomiting or nausea. Now, in the study of diseases of women, which it is my privilege to discuss before you, there is nothing more important than forming habits of accurate and correct diagnosis. This, in some cases, is an exceedingly difficult problem; in many it may be simply inferential and can only be confirmed after extraordinary means have been exercised to determine the diagnosis. I bring this patient before you for the purpose of discussing the diagnosis of disorders of the abdomen. In the consideration of the subject you endeavor first to elicit those symptoms which the patient herself can give you, and are hence known as subjective. In many cases you will thus attain a pretty strong inference as to the probable disorder; but while subjective symptoms are important, should always receive due consideration and should be the first step in your investigation, you should not depend upon them solely in arriving at your conclusion, for in doing so you will be frequently mistaken and misled. You should place yourself in the position of a judge who hears the evidence on both sides, weighs it carefully, and only comes to a conclusion after a careful analysis of all that has been given.

Now, this patient has a family history that is bad; mother and some of the family died of phthisis. We have her individual history, her age—seventeen—cessation of menstruation for five months. Coincident with this cessation there has been a development or enlargement of the abdomen. These symptoms may be considered as giving a strong inference of a particular condition, but should not be considered as a positive indication. Any one, deciding such a case, without having gone further into the examination, or into the analysis of the subjective symptoms, with those that may have been obtained by a careful physical examination, will frequently find himself making serious mistakes. Having, then, elicited the history of the patient, we proceed to investigate the physical signs or those symptoms that are usually denominated as objective. To do this we proceed in a regular manner. Thus, the patient will be placed upon a couch or table, with the clothing loosened and so arranged that the abdomen will be exposed. It is well that the patient should be directed to have the bowels evacuated and urine voided. The methods of procedure in examination may be divided into inspection, palpation, percussion and auscultation; and under the term palpation we may include mensuration.

With the abdomen exposed, drawing a sheet over the lower extremities and

bringing it down over the pubes, the abdomen is subjected to inspection. As we do so, we see this abdomen is considerably enlarged, that this enlargement is symmetrical, that there is a dark line running down its center, particularly marked between the umbilicus and symphysis; that the umbilicus itself is projecting and there is possibly a deepening of the pigment over the abdomen. In some cases we would see a large number of cicatrices known as striæ over the flanks and lower part of the abdomen; we may find the skin discolored by indications of previous application of counter-irritants, such as blisters and various agents that have produced eruptions. These would indicate the existence of previous inflammatory trouble, as it is quite improbable that such applications would be made unless there was some diseased condition present. The striæ occur upon the surface of the abdomen, may either be purplish in appearance or white and glistening. The former indicates the recent occurrence, the latter those that have existed for some length of time, possibly from previous distension. The striæ of these surfaces or cicatrices are the result of stretching of the skin and rupture of its middle layer, the rete malpighii. Busey, after careful investigation, concluded that they were due to atrophy of the lymph spaces. They occur as a result of any distension of the abdomen, whether tumor, ascites, pregnancy or obesity, and consequently have no diagnostic significance. The dark line seen upon the abdomen, known as the linea nigra, occurs as a result of pregnancy, and once present, never subsequently disappears. It cannot, however, be considered as a positive indication of pregnancy, for the reason that it is found as a result of disordered conditions of the uterus and of the ovaries; more likely to be found in dark-complexioned women. The symmetrical development of the abdomen or the presence of irregularities deserves consideration. Thus, thedistension of any portion of the abdomen affords an inference as to the possible organ from which it has taken its origin.

For convenience and purposes of study we divide the abdomen by two lines drawn transversely, the upper from the level of the ninth costal cartilage and the lower from the crests of the ilia, and these by perpendicular lines drawn from the eighth costal cartilage to the middle of Poupart's ligament. These lines divide the abdomen into nine spaces. Now, we know by our previous study the contents of these different divisions, and when any swelling or distension is found to predominate in one, we recognize that it must arise from one of the organs or a part of the viscera contained therein. Thus, a tumor confined to the lumbar region upon either side would probably arise from the kidney or from the ascending or descending colon; growths which take their origin in the lower part of the abdomen and develop upward must arise either from the uterus, the ovaries, the tubes, the broad ligament, the rectum, the cæcum, or the glands of the pelvis; so by a process of elimination we are enabled to determine to a certain degree, by the mere inspection of the abdomen, with the clinical history, the character of the diseased state present.

Now, in this patient you will notice that the tumor is a symmetrical one; by

that we mean that it is situated about equally on either side; if anything, it projects slightly at the upper part to the right side; this is not an infrequent occurrence in tumors that take their origin from the pelvis, whether it be due to pregnancy or to a growth of the uterus or of the ovary. The distension upon the right side is attributed to the fact that the rectum is situated more to the left and its distension leads to the right displacement. Inspection of the abdomen also would reveal any irregularities in the growth and not unfrequently we may observe the movement or projection of the abdominal walls as a result of movement within. These movements may arise as a result of muscular contraction, peristaltic action of the intestines, or from fœtal movements. All that I have mentioned that may have been observed through inspection can be accomplished by a casual glance or during the same time the palpation of the abdomen may be made. This is done by placing the hand over the abdomen, having the fingers previously warmed to prevent shock and irritation. The hands may be applied close together, moving them from one side to another or widely apart, thus bringing between them the entire abdomen. Rough or careless manipulation will defeat its object, as it will cause contraction of the muscular fibres, rendering it more difficult to palpate the structure within. By palpation we determine the resistance and density of the growth, its elasticity, movabililty, any irregularities upon its surface, the presence of adhesions, and in placing the hand upon one side and striking against the abdomen with the other, we may elicit the sensation of fluctuation.

The hands placed over the abdomen and kept quiet, we may not unfrequently recognize vermicular motion of the structures within. This was pointed out by Braxton Hicks as being an indication of the existence of pregnancy. In some cases the hands so applied, we will be able to recognize distinctly the movements of the fœtus within the walls. It should be remembered, however, this is sometimes capable of misinterpretation. It is well known that the kingdom of England rejoiced at the probability of Queen Mary giving birth to an heir; even her physicians had recognized fœtal movements; but the condition proved to be a phantom tumor and the movements noticed were contractions of the abdominal walls. Now, finding that the tumor has gradually increased in size, that there is a history of previous cessation of menstruation, that it is symmetrical in outline, and spherical in shape, presents no irregularities, that there is muscular action of the uterus, and it is distinctly recognized that a mass can be felt within the growth, while the growth itself is elastic, the indication is very strong that we have to deal with pregnancy; but even with symptoms of this character you should not be absolutely certain until other methods of examination have been exhausted, as it is known that women have been considered to be pregnant when it afterwards proved that conditions entirely different were present; that patients have been unjustly accused of want of chastity and have suffered as a result of it, when they were the victims of abnormal growths. The importance of careful and accurate diagnosis may be appreciated when it is remembered that not infre-

quently the abdomen has been opened by men of experience, and even the pregnant uterus itself punctured for supposed abnormal growths. Having ascertained the physical signs to be determined by palpation we may proceed to percussion. The principal advantage of this is that we are enabled to outline more distinctly the growth and its character. It is well known that the abdomen may be symmetrically distended, with an apparent growth which percussion discloses to be a mere accumulation of gas within the intestines. With thick abdominal walls such an accumulation might be exceedingly difficult to determine otherwise than by percussion.

Percussion may be done by the mediate or immediate methods. It should be remembered, however, that a coil of intestine situated over a growth may in light percussion give rise to resonance, in deep percussion to dulness. In this patient you will notice that the resonance is marked upon the side and above the mass, while over the mass resonance is absent. In this way we can determine the extent of the growth and its actual presence. Percussion is of particular value in cases of disease in which we have to deal with fluid in the abdomen. We may be in doubt in the particular individual as to whether the fluid is situated in the sac or free in the peritoneal cavity, forming in the former condition a cyst, in the latter, ascites. In percussing over an abomen containing free fluid, we will find the point of greatest resonance is over the highest part of the distension in whatever situation the patient may be lying. Thus, the patient is in the recumbent posture, the central part will be resonant, while over the sides it will be absent, when the line of resonance changes with position of the patient. If the abdomen contains free fluid, its surface will be somewhat more flat and distended laterally than if the fluid is contained within the cyst. Where the fluid is contained within a cyst, percussion is dull over the surface of the tumor, while resonance occurs above it and also generally upon one side. The resonance upon the side is due to the fact that as the tumor which has its origin from one side increases in size, it pushes the intestines upward and to the opposite side, so that the side on which resonance is present is the one usually opposite to that in which the tumor has originated. In free fluid the resonance is distinct over the summit of swelling for the reason that viscera containing air, being lighter than the fluid, float upon the surface and are in direct apposition with the percussed surfaces. There is, however, a chance for error in those cases in which, as a result of inflammation or enormous distension, the mesentery is too short to permit the intestines to float in contact with the abdominal wall. A layer of fluid intervening would give rise to absence of resonance upon light percussion. If the finger, however, be pressed into the abdominal walls until the intervening layer of fluid is displaced, resonance will then be found. In other words, dulness upon light percussion, resonance upon deep pressure. In some cases, particularly where the intestines have been firmly bound down and fluid is encysted, it may be exceedingiy difficult, if not impossible, to arrive at a certain diagnosis without exploratory incision. Another method of examination is that by auscultation.

This is practised by placing the ear either directly or simply with a sheet intervening over the abdomen, or we may use a stethoscope. The former method of procedure is better for determining the situation of the sounds, the latter for acute observation. Sounds that are likely to be heard are those of the fœtal heart, murmur of the blood passing through large vessels of the uterus, and the sound produced by the umbilical cord, which is known as the umbilical souffle. The latter takes place as a result of pressure upon the cord, increasing the friction of the blood passing through the vessels.

Again, we may have gas in the intestines or a crackling sound of gas within the uterus. This latter is more particularly likely to occur in those individuals in whom the fœtus has been dead for some length of time. The process of decomposition gives rise to the formation of gas within the cavity of the uterus. The uterine souffle was formerly called the placental souffle, as it was supposed that it was due to the blood in the placenta, as the sounds were also heard in women having large uterine tumors; it was recognized to be due to the current of blood passing through the uterine sinuses. The one sound which cannot be mistaken for any other, and which once heard, will not be forgotten, is that of the fœtal heart; when this can be distinguished there is no question but what a patient is pregnant. Even though the woman should have a tumor for a length of time, the existence of these sounds would indicate that it was complicated by the presence of pregnancy.

Now, in the patient before us, you will remember that her menses ceased in March; that there was a gradual increase in the abdomen since; that the patient gives a history of exposure to the possibility of pregnancy. Upon examining the abdomen we find the dark line down its center, a protruded umbilicus, the abdomen with the tumor rising as high as the umbilicus, which is symmetrical in its development, the tumor regular in outline, presenting a sensation of elasticity; it is not firm and resistant and upon deeper pressure we can feel within the walls of the growth a mass more resisting, and by placing the hands over the flank upon either side and approximating them, we can bring between them a mass which we recognize as apparently the head of the fœtus. In listening for the heart sounds, I have been unable to distinguish them, but yet I have no hesitancy in affirming that this woman is pregnant. It should be remembered that the absence of fœtal heart sounds is not a positive indication either against pregnancy or that the fœtus is not doing well. The examination of the patient in the manner we have already suggested is not only of value in determining that she is pregnant, but by it we may also be able to arrive at a definite conclusion as to the position of the child, and consequently form an idea as to the ease with which her labor may be accomplished. By palpation we may be able to determine the position of the fœtus; indeed, we may form an inference as to this by the inspection of the abdomen; thus, if the abdomen is much larger transversely with a projecting mass upon one side and a similar upon the other, we would be led to suppose that we had to deal with a transverse presentation. This would be distinctly determined by feeling upon one side a mass sufficiently

resistant to indicate its being the head of the fœtus and upon the opposite side the breech. The most frequent position, as you know, is that in which the head is situated with the occiput directed to the left and anterior. An inference may be formed as to this position by the appearance of the abdomen. The uterus will appear in a spheroidal shape with its longest diameter vertical. The position of fœtus is still further determined by placing two hands over the abdomen and determining the presenting part. If this be the head, it will be more firm and resisting than will be the breech. Carrying the hand back over the trunk, there will be found to be a depression between it and the head, and the trunk can be readily traced through the abdominal walls to the breech, which is situated to the right and above. The limbs will be felt on the opposite side. In listening for the heart sounds we may further confirm our diagnosis of the position by noting the point at which they are most distinctly heard. Thus, in the left occipito-anterior, the heart sounds are readily heard below the level of the umbilicus to the left side of the median line. In a breech presentation the lower end of the fœtal pole would be less resisting, no separation or depression appearing between it and the trunk, and the fœtal heart sounds would be heard at the level of the umbilicus.

The next patient I bring before you is a woman twenty-eight years of age, who has not had her sickness for nearly nine months; the abdomen is very largely distended, as high up as the epigastrium; the abdominal walls are thick, rendering it very difficult to determine with accuracy the diagnosis. The thickness of the abdominal walls renders palpation exceedingly difficult, so that we can obtain very little information of the condition of the parts within. You will notice that the abdomen is marked by a large number of cicatrices over its entire surface. These are pearly and glistening, showing that they have been produced by a previous distension of the abdomen.

SYMPHYSIOTOMY, WITH THE REPORT OF AN OPERATION.*

BY BARTON COOKE HIRST, M. D., OF PHILADELPHIA.

Symphysiotomy has as remarkable a history as any procedure in surgery. Suggested for the first time in the Surgery published by Pineau in 1598, and first performed upon a living woman in 1777, the idea may be said to be three hundred years old, while its practical application dates back more than a century.† From the year of the first operation until 1858 symphysiotomy was performed 85 times in different parts of the Continent of Europe and once in England with a mortality of 33 per cent. The frequency of the operation diminished after the first few years, until in 1858 it had practically died out. It was revived, however, in Italy in 1866, and in the succeeding twenty years 70 operations were performed with a mortality of 34 per cent. Italy continued to be the exclusive field of the operation until a year ago, when it was again tried in Paris by Pinard,

*Read before the Philadelphia County Medical Society, October 12th, 1892.
†R. P. Harris: Amer. Syst. of Obstet., vol. ii.

whose interest in it was aroused by a visit of Spinelli from Italy. Ten operations have since been performed in Paris, two in Dresden, and one in Strassburg. From January 1st, 1886, there have been 52 operations with only a single death, due to septic infection before the operation was undertaken. Twenty-three symphysiotomies have been done already this year; and the last 34 women have all recovered.

We owe the introduction of symphysiotomy in this country to Dr. Robert P. Harris, who, as is well known, has long been interested in the subject, and at the recent meeting of the American Gynæcological Society in Brooklyn read a paper tracing the development of the operation, showing by the most laboriously collected statistics the present brilliant results achieved by it, and demonstrating, by the description of typical cases, its utility in labors otherwise insuperably obstructed by a contracted pelvis.

Ten days after Dr. Harris's paper was read, on September 30th, the first operation in this country was performed by Dr. Charles Jewett, in Brooklyn. Three days later it was again performed at the Maternity Pavilion of the University Hospital in this city.

The position of symphysiotomy is now established beyond a doubt. Its modern revival I believe to be the most important advance in obstetric surgery since the general adoption of abdominal section for the treatment of early extra-uterine pregnancy. It is applicable in contracted pelves with a conjugate over 67 mm., and, therefore, should be the method employed in almost all cases of the kind in this country, for a greater contraction of the pelvis is rarely seen among us. It should, moreover, almost entirely displace the Cæsarean section for a relative indication. It is a much simpler, an easier and a safer operation. This is also the opinion of Leopold, who cannot be accused of prejudice against Cæsarean section, with his brilliant record in that field.

There is and will be for some time, perhaps, an objection to the operation from those who have no experience with it, on the ground that sufficient space cannot be thus gained. In answer to this objection is the fact that the pubic bones may gape 7 cm. after separation, and the statement of Morisani, that the conjugate is thereby increased from 1.3 to 1.5 cm. But an absolute conclusive answer is furnished by the subjoined clinical records of some typical cases.

Leopold's First Case.‡—A dwarf, 135 cm. tall, with the following pelvic measurements: Sp. il., 22 cm.; cr. il., 24 cm.; tr. 28 cm.; conj. ex., 17½ cm.; conj. diag., 8¾ cm.; conj. vera, 6¾ cm. She had been delivered thrice previously, twice of dead children, one by the induction of premature labor. After a labor of seven hours and twenty minutes, ushered in by rupture of the membranes, symphysiotomy was performed with the head above the brim. In ten minutes the child was extracted with forceps. The head was of normal size (transverse, 9¾, 8¼; circ., 34).

Leopold's Second Case.§—A woman, delivered once before by craniotomy. The

‡Centralbl. f. Gyn., 1892, No. 30.
§Centralbl, f. Gyn., 1892, No. 30.

pelvic measurements were as follows: Sp. il., 22; cr. il., 25; tr., 30½; conj. ext., 16; conj. diag., 8½; conj. vera, 6¾. Labor began in the evening; membranes ruptured seven hours later; operation three hours later with head above the brim. Extraction of the child in ten minutes with forceps. The head had a circumference of 35¼ cm.

Porak's Case.‖—A primipara with rhachitic pelvis, conjugata diagonalis being 9.6 cm., and pelvis presenting some asymmetry, very likely from scoliosis. Labor began on June 10th. About twelve hours later the membranes ruptured, and from eight to ten hours afterward the os was completely dilated. The head rested above the brim of the pelvis. Forceps were applied, but all efforts to engage and extract the head failed. The symphysis was opened, and the head then extracted "with the greatest ease" by forceps. Recovery.

Freund's Case.¶—A women, in labor six days; water drained off for two days. After opening the symphysis the head was delivered in fifteen minutes without instruments. There were two previous deliveries, one of a dead and one of a living child. The pelvic measurements were: Sp. il., 24½; cr. il., 27; tr., 31; conj. ext., 18½; conj. diag., 10 cm.; conj. vera, 8¼. The child's head after birth was found unusually large and hard. B. T., 10 cm.; B. P., 11 cm.; F. O., 12 cm.; M. O., 14cm.; S. B., 10 cm. Circumference, O. F., 37 cm. Recovery.

Jewett's Case.†—The first symphysiotomy in America, performed by Dr. Charles Jewett, of Brooklyn ,September 30, 1892. Woman, a native American, primipara, fell in labor September 30, one o'clock, A. M.; the occiput appeared at the vulva, but was held fast by an approximation of the ischiac tuberosities. reducing the bisischiac diameter to three inches. Nine hours later Dr. Jewett first saw the patient. The forceps had been vigorously used in vain. Symphysiotomy was performed two and one-half hours later, or eleven and one-half hours after the impaction of the head at the outlet. Delivery was effected by suprapubic pressure and by shelling the head out with the fingers in the rectum, The woman is now in good condition, but unfortunately the child died twenty-four hours after birth, from the compression to which the skull had been subjected during its long impaction in the pelvis.

The University Maternity Case.—A German woman, aged nineteen, pregnant for the first time, was admitted to the University Maternity September 24th. The examination by the resident physician and the students showed the child to be presenting by the head, the back to the right. The pelvic measurements were: Sp. il., 25 cm.; cr. il., 27. cm.; tr., 30½ cm.; conj. ex., 18 cm.

The internal examination made by myself just before operation showed the conjugata diagonalis to be 9½ cm.; conj. vera, 7¾ cm. The girl fell in labor Saturday morning, October 1st. The pains, recurring all day, on Sunday became very vigorous. On Monday morning when my attention was first called to the case, the contraction-ring was high, the uterus stood almost straight out from the body, and the child's head was movable above the superior strait. The mem-

‖Annales de Gynécologie, September, 1892.
¶Mullerheim: "Ueber die Symphysiotomie," Centralbl. f. Gyn., 1892, No. 30.
†Personal communication.

branes were unruptured. By no justifiable degree of force could the head be made to enter the pelvis. The fœtal heart-sounds were good. It was evidently, therefore, a choice of Cæsarean section, craniotomy, or symphysiotomy. This last was done with the assistance of Dr. R. C. Norris and the valuable advice of Dr. R. P. Harris, who kindly consented to be present. The child was delivered with forceps in one hour and four minutes from the time the operation was begun. I purposely took my time, for the os was only the size of a dollar, and was very rigid, so that a more rapid extraction would have seriously injured the cervix. Head measurements: B. T., 7½; B. P., 9; F. O., 12; M. O., 13½; circ. 34. Mother and child are well.

The technique of symphysiotomy is simple and easy. After thoroughly cleansing the field of the operation and disinfecting the vagina as well, a short vertical incision is made on the abdominal wall, reaching to about three-quarters of an inch above the symphysis. The attachments of the recti muscles are severed just sufficiently to admit one finger. The forefinger of the left hand is passed under the symphysis, and upon this as a guide the curved knife of Galbiati is inserted until its beak projects under and in front of the symphysis. The joint is then cut upward and outward. To avoid injury to the urethra, a metal catheter is inserted and pressed by an assistant downward and a little to the right, while the knife is placed a little to the left; but with Galbiati's knife I should think that there is little likelihood of cutting the urethra or the plexus of veins in its neighborhood. I at first thought that an ordinary probe-pointed, curved bistoury would serve my purpose well enough, but I quickly laid it aside, and was glad to avail myself of Galbiati's knife, which I happened to possess—at the time one of three, I believe, in the country.

As soon as the joint has been severed, the wound should be covered with iodoform gauze, and then the child extracted with forceps, or allowed to be delivered naturally, as seems best in the individual case. I should, I think, almost always prefer the forceps. It is well to have trochanters supported by assistants during the passage of the child through the pelvis, so that the sacro iliac joints shall not be injured.

As soon as the delivery is completed the wound is sewed up, the lowest stitch, if desired, passing through the top of the symphysis. How the whole symphysis can be stitched up, as Leopold claims to have done, I do not understand. After closing the wound and dressing it, rubber adhesive strips are placed around the hips and the lower abdomen, and a tight binder applied. The symphysis unites surprisingly soon, and three weeks after the operation the patient can walk as firmly and as well as ever.

There is only one disturbing thought in connection with the introduction in this country of an operation destined to do so much good. The charge of superficiality lies with some justice against us. We are too ready to reach out toward the top without a sufficient basis of solid preparation, and I fear that symphysiotomy may be undertaken by many who cannot correctly measure a pelvis and

who have not the experience to decide whether a head can pass through the pelvis in which it is about to enter or in which it is engaged. There is consolation, however, in the reflection that if symphysiotomy should be done needlessly the results are not likely to be so disastrous as in the case of Cæsarean section, which, to my knowledge, was done several times unnecessarily during the excitement produced among medical men by the improved results of the Sänger operation.

LACERATION OF PERINEUM AND CRACKED NIPPLES.

From Swatow, China, Dr. Alice Ross writes to the *Medical and Surg. Reporter*, October 8th:

My attention was called some time ago by Dr. Walter J. Cree, of Detroit, to a certain relation existing between complexion and laceration of the perineum and cracked nipples. My observations entirely coincide with his, and I am curious to know if others have observed the same thing. In red-haired women and those brunettes who have red lips, red cheeks, and are inclined to freckle rather than to tan, lacerated perineum and cracked nipples occur most frequently. While those sallow-skinned blondes who tan rather than freckle and who have a tendency to a deposit of pigment in the areola of the nipple, about the neck and armpits, are least liable to suffer from these accidents. The first class seem to have friable tissues and thin skin, and the second, tough muscles and thick skin. Other women are liable to suffer or are able to resist as they lean toward one type or the other. This relation is to me marked, and is of value in prophylaxis.

POISONOUS SYMPTOMS CAUSED BY EUCALYPTUS GLOBULUS.

Dr. Benjafield writes from Tasmania to the *Lancet:*

"I have been called in to cases of apparent poisoning by eucalyptus globulus, but all of them soon recovered. E. G—, aged two years, climbed up to her mother's store of household medicines, and poured about a teaspoonful of pure oil on some sugar and swallowed it. Within half an hour she began to stagger. Then she became violently sick and lost all power over her legs, so that when attempting to stand she dropped down helpless. A sort of intoxicated torpor then set in. We could awaken her by shaking her and calling, but she immediately relapsed. The pulse was quick and strong; the pupils were slightly contracted. This lasted for about three hours, when she woke up perfectly right and ate a good meal. Another child drank an unknown quantity out of a bottle and had the above symptoms very marked; also had great difficulty in breathing; but, by report brought to me from the Bush, where it occurred, she recovered. From experience here, where we have never seen Asiatic cholera, I should expect it to be a good germicide and stimulant for this disease. It might safely be given in half-drachm doses, which would quickly saturate the system with the drug; or drachm doses in milk might be injected into the bowel."

The recent report of the Commissioners of Customs has one new feature in an actual decrease in the amount of revenue from wine, there having been a lessened yield of £27,000. Unhappily, however, there has been an increase of over £750,000 on the revenue from all spirits, though foreign spirits have dimminished by £164,000. There has been a small gain in rum, but a very large increase in brandy, which, in the language of the report, "appears to have taken a fresh hold on popular favor." In the interests of the public health it is to be regretted that the increase has been in the stronger beverages.—*Brit. Med. Jour.*

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BALTIMORE, OCTOBER 29, 1892.

Editorial.

"ORIFICIAL SURGERY" AGAIN.

In another column we publish a letter from Dr. Stevenson in criticism of our recent editorial upon this subject. There must surely be a misunderstanding in regard to the meaning of the terms used; for we heartily endorse our correspondent's testimony in regard to the need of examining every organ or region that is likely to be the seat of reflex trouble in obstinate disorders of the general organism in which no definite cause has been found. Furthermore, we have never had the remotest idea of asserting that the surgeon ought not to operate on an "orifice" of the body, if it is so diseased as to call for operation. We are also well aware (we learned it long ago from standard text-books written before the period at which the "modern application of *orificial principles*" is said to have been first made) that a fissure of the rectum or a vascular growth in the female urethra could produce disturbances of the general nervous system wholly disproportionate to the smallness of the growth.

If these are the truths for which our correspondent contends, and we believe that they are, then we have certainly no dispute with him. If we have seemed to deny such facts in the editorial referred to, we most humbly apologize to him and to any other reader who has so understood us.

We do, however, most earnestly assert that "Orificial Surgery," as it is represented by certain articles found in the journal referred to, bears the impress of the "fad"; that the terms in which it is spoken of by its promoters are not those of thoughtful, critical, judicial search after truth; that its pursuit in the spirit of the writers referred to is likely to lead to narrow and partial views of disease-conditions; so that undue prominence will be given to unimportant phenomena, symptoms will be mistaken for causes of disease, and a great deal of false diagnosis, useless operation, and unnecessary suffering (to say nothing of peril to life) will ensue. The very name of the great "American Operation" savors of sensationalism.

If the professional gentlemen who have had their attention specially directed to the influence of rectal, urethral or uterine disease upon the human organism will proceed in a calm and critical spirit to urge this fact upon the attention of the medical profession, even by the aid of special journals (though we deem these unnecessary) we shall be glad to listen to their testimony; but the tone adopted by the enthusiasts whom we criticised must necessarily beget distrust in the minds of prudent readers. A few facts may perhaps be discovered through "Orificialism," as we suggested in the editorial; but the thing has taken on the aspect of a fad, and will be likely to work far more harm than good, as men of large ambition and little principle push their way to its front.

We hope our correspondent will take these words in good part (as they are kindly meant) and will enquire carefully into the spirit of the movement.

OUR WEEKLY CHRONICLE.

THE SEMI-ANNUAL MEETING, ETC.

The Executive Committee of the Medical and Chirurgical Faculty of Maryland has decided that the semi-annual meeting at Easton shall begin Tuesday, November 15th, and continue throughout Wednesday, November 16th. Dr. E. R. Trippe, of Easton, Chairman of the Local Committee, reports that ample provision has been made for the reception of visitors. There is a large hotel in the town.

A large number of "titles" of papers have already been handed in by Drs. William Welch, William Osler, William S. Halsted, J. F. Finney, J. E. Michael, Robert L. Randolph, S. T. Earle, J. Whitridge Williams, Robert T. Wilson and others. All candidates for membership are requested to send in their names on or before the 12th of November to Dr. T. A. Ashby, 1125 Madison Avenue, Chairman of Committee of Arrangements and Program, or Dr. G. Lane Taneyhill, 1103 Madison Avenue, in the city, or to Dr. W. F. Hinds, of Chestertown, Md., Chairman Examining Board for Eastern Shore.

Programs and circulars of information will shortly be mailed to all the members of the Faculty, and also to many physicians resident on the Eastern Shore.

Physicians of Baltimore desiring to enjoy a very delightful excursion on the bay, may take the boat which leaves the city at 4 P. M., Monday, November 14th. By this route, the latter half of which is by rail, they will reach Easton in time for eight o'clock supper the same evening.

We are glad to learn that Dr. Henry P. C. Wilson, who has been quite ill with symptoms resembling pneumonia, is now out again and about to resume the care of his practice.

Dr. W. H. Feddeman, of Hampden, Baltimore, has entered into the bonds of matrimony.

An arrangement has been made between the telephone company and the druggists' association of this city, in accordance with which the charge for telephones is to be $78 a year, only one telephone being on each circuit at present. The

druggists have also, we understand, assumed certain obligations to the company in regard to extra charges for non-subscribers' messages. It is to be hoped that this will restore to physicians the benefits of telephone communication formerly enjoyed, and will be attended by improvement in the service, which was formerly very poor indeed on many lines.

Dr. P. C. Williams has bought the house at the south-west corner of Cathedral and Howard Streets and will shortly occupy it. The Biddle Street electric road makes his old residence, corner of Madison and Biddle Streets, too noisy for office work, and when the cable road on Madison Avenue begins operations it will add greatly to the din.

The State Board of Medical Examiners, appointed under the *New Medical Law*, has not been idle. We hope to publish a report of its operations in our next issue. We desire to state that, in spite of our recent dispute with this Board, the JOURNAL and its editor are thoroughly in sympathy with its main purposes, and will aid in every practicable way in encouraging its work.

TO SUBSCRIBERS.

We are requested by the proprietor of the JOURNAL to call attention of subscribers who are in arrears to the fact that a journal cannot be expected to thrive if physicians who take it neglect the payment of their subscriptions. Checks for even one year's subscription, or postal notes, are always welcome from persons who cannot call at the office and pay up.

In improving the journal (as has been done during the last half year, in regard to both matter and appearance) the proprietor looks to the profession of the State for appreciation and encouragement.

Reviews, Books and Pamphlets.

Materia Medica, Pharmacy, Pharmacology and Therapeutics. By W. HALE WHITE, M. D., F. R. C. P., Physician to, and Lecturer on Materia Medica and Therapeutics at Guy's Hospital, London; Examiner in Materia Medica to the Conjoint Board of England; Author of a Text-Book of General Therapeutics. Edited by Reynold W. Wilcox, M. A., M. D., LL. D., Professor of Clinical Medicine at the New York Post-Graduate Medical School and Hospital; Assistant Visiting Physician to Bellevue Hospital; Fellow of the American, and of the New York Academy of Medicine, etc. Philadelphia: P. Blakiston, Son & Co. Pp. 607. Price $3.00.

Books on this subject are so numerous and appear with such regularity each year that it might seem as if this addition were superfluous; but at the very first glance the size of the book is seen to be in its favor. Most works on Materia Medica are long and too full for the student. The author and editor have brought out a book both compact and without omissions which should appeal to every under-graduate as of especial help in the class-room. Throughout this book it is not always easy to distinguish the author's from the editor's work; still it is not difficult to see that the American Pharmacopœia and other Ameri-

can works have been thoroughly consulted by the editor to add a large number of remedies, both officinal and unofficinal, which are used in this country.

This book opens with definitions, then takes up the action of drugs on the different organs and parts of the body, and then treats of general therapeutics, inorganic and organic. Great brevity of expression is shown throughout this work and in some places it is almost too lexicon-like to brighten the usually dull subject of Materia Medica. The use of quinine is described as empirical; some might call this in question since the discovery of Laveran.

The effect of drugs on the urine is a very important section and has received the proper attention here.

It would seem almost folly to attempt to point out faults in a book which has already been adopted as a text-book by several colleges, not the least of which is the Harvard Medical School.

On page 10, line 26, "United States' Pharmacopœia" is printed instead of "United States Pharmacopœia." "Antihidrotic" occurs in the text, while the proper spelling, "antihydrotic," is found in the index and in standard medical dictionaries. There are occasional errors of reference in the index. The directions how to make a mustard plaster may seem unnecessary to some readers but are very timely to the student, who is so seldom taught the important details of treatment. The reputation of the author and editor will be sufficient guarantee of the practical usefulness of the book, and it is sure to find a place in many schools of this country and England. The book is printed and bound in that excellent style so characteristic of all the work of these publishers.

The Hygiene of the Sick-Room; a Book for Nurses and Others; being a brief consideration of asepsis, antisepsis, disinfection, bacteriology, immunity, heating, ventilation, and kindred subjects; for the use of nurses and other intelligent women. By Wm. Buckingham Canfield, A.M., M. D., Lecturer on Clinical Medicine and Chief of Chest Clinic, University of Maryland; Visiting Physician to Bay View Hospital, etc. Small 8vo., 250 pages, cloth, $1.50. Philadelphia: P. Blakiston, Son & Company, 1810 Walnut St., 1892.

This neat manual is the outcome of a series of lectures delivered before the University of Maryland Training School for Nurses.

In this treatise the author, who is already well-known to the medical world through translations and original works presented to the profession during the past ten years, has found peculiarly congenial and familiar themes for consideration, since he is thoroughly familiar with the present status of bacteriology.

His book is a great success, and will add much to his growing reputation as a writer. We recommend it to the attention, not only of sick-nurses, but also all other persons, of either sex, who desire a knowledge of the behavior of disease, as it concerns infection; and the manner in which foulness, either of wounded surfaces, or of the sick-room, or of the dwelling house may be prevented.

Each disease is taken up in turn (typhoid fever, consumption, diphtheria, etc.) and the methods of management of the discharges, etc., are described in detail. The formulæ for the preparation of disinfecting solutions, for clothing, utensils, privies, etc., are clearly set forth; such details as one may search his library in vain for are here given in a compact form.

The prevention of blindness in infants (with the recommendations of the committee of our State Faculty on the subject) receives full attention. Ventilation is duly considered, and a chapter is given to the thoughtful discussion of immunity and protection from disease. The book closes with some remarks upon the

diet of the sick-room. We congratulate Dr. Canfield on his work. It is well worth its moderate price.

Napheys Modern Therapeutics, Medical and Surgical, including the Diseases of Women and Children. A compendium of recent formulæ and therapeutical directions from the practice of eminent contemporary physicians, American and foreign. 9th edition, revised and enlarged. Complete in two thick octavo volumes. Volume I. General Medicine and Diseases of Children. By ALLEN J. SMITH, M. D., Physician in the Dispensary for Diseases of Children, Lecturer on Urinology, etc., University of Pennsylvania, etc., and J. Aubrey Davis, M.D., Assistant Demonstrator of Obstetrics, University of Pennsylvania, etc. Philadelphia: P. Blakiston, Son & Company, 1012 Walnut Street, 1892. Cloth, $5, Leather, $6.

In this work the busy practitioner will find the treatment of each disease according to several authorities; with a list added of many remedies used by the general profession in its treatment, and the indications for which each is prescribed. There are many prescription-formulæ throughout the book which may serve as suggestions for the combination of remedies or for the ordering of new agents not before thought of.

The work is now issued in two large volumes, instead of four small ones, as formerly. There is much new matter in this edition and some old matter now useless has been omitted. To all practitioners who desire such a work of direction and suggestion in prescription forming, we recommend a consideration of that now before us.

Index-Catalogue of The Library of the Surgeon-Generals' Office, United States Army. Authors and Subjects, Volume XIII. Sialagogues-Sutugin. Washington: Government Printing Office, 1892.

This volume is a continuation of the admirable general index to the whole library, covering its part of the field to date. The Index Medicus is a supplementary catalogue of all publications as they are received month by month. The Index-Catalogue is too well known to literary workers of our profession to need especial comment from us; it does not in any way concern physicians who take no interest in general medical literature.

A Manual of Medical Jurisprudence, by ALFRED SWAINE TAYLOR M. D., F. R. S. Revised and edited by Thomas Stevenson, M. D., London, Lecturer on Medical Jurisprudence and on Chemistry at Guy's Hospital, London, etc. Eleventh American edition, with citations and additions from the twelfth English edition, by Clark Bell, Esq., President of the American International Medico-Legal Congress of 1893, etc. Octavo, Cloth, 790 pages, with 56 Illustrations, $4.50, Leather, $5.50. Philadelphia: Lea Brothers & Co., 1892.

This work is the authority recognized, not only by the medical profession, but also by the courts of all English-speaking countries. The present (9th) American edition, being based on the last English edition, has had the benefit of successive revision by the foremost medical experts, and finally by a legal authority who has made the subject an especial study from the standpoint of American practice, extensive notes being introduced at points where our laws and legal interpretations differ from those of the mother country.

In view of the fact that he may be at any time involved in medico-legal procedures, every practitioner should have a standard work on medical jurisprudence, such as that before us, in his library, and should acquaint himself before-

hand with his best method of conduct in cases which may possibly lead to legal investigations.

Memoranda on Poisons, by Thomas Hawkes Tanner, M.D., F. L. S. Seventeenth American from the last London edition, Revised by John J. Reese M. D. Late Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania. Philadelphia: P. Blakiston Son & Co., 1012 Walnut St. 1892. Duodecimo, 177 pages, Cloth, 75 cents.

The popularity of this little manual is shown by the number of editions issued. It is a handy guide for physicians in busy practice.

It first treats concisely of the diagnosis and treatment of poisoning and the detection of poisons, and then proceeds to the consideration of the symptoms and treatment of each separate poison or group of poisons which may confront the practitioner.

Correspondence.

THE "ORIFICIAL FAD."

CAIRO, ILLINOIS, October 8, 1892.

Editor Maryland Medical Journal:

DEAR SIR:—In your journal of September 17th last appeared a short editorial entitled "The Orificial Fad," which I read with much interest, and desire to criticise, if you will kindly permit me. I take this liberty because I am an old subscriber to the journal, and have always found it liberal, tolerant, and, while holding tenaciously, and with commendable zeal to the faith as expounded by the regular school of medicine, ready to accord due credit for any new thing proving meritorious.

I belong to this school myself, being a graduate of the University of Maryland; and after twelve years of practice, I find no reason to wish to change my faith.

But I am a very enthusiastic admirer of orificial surgery, as I am convinced every one must be who will resort to it in properly selected cases.

If a man does us a favor when we are in a very tight place, helping us when all other help has failed, we will naturally have a very warm feeling in our hearts for him. If he repeats the kind office as often as our needs exist, we would be less than human if we did not revere him as our best friend, and fly to his defense if we found his character assailed.

Now, orificial surgery has proven just such a friend to me, and I know you will pardon me for desiring to say a few words in its favor.

It cannot be properly called the product of "medical speculation." It is true of late there has been much speculation in connection with it, but this has come in the effort to establish the theory connected with the already acquired brilliant results of practice. The modern application of orificial principles dates back only ten or twelve years, but we are told that the bivalve was one of the discoveries among the ruins of Pompeii, and that the rectal plug still exists. which cured Louis XIV of hæmorrhoids. As iswell known, there has been a steady growth of thought and practice along these lines during the intervening years, until, with a few bold strokes, later disciples brought the orificial science into its present state of perfection, taking such long strides, in fact, as to give it all the freshness, vigor and virtues of an entirely new discovery.

It does not deserve the name of a "fad." Its principles are scientific and its results, in many instances, as you intimate, miraculous, while it has so far mod-

estly claimed recognition only in cases where every other known remedy has failed. In my own orificial practice of three or four years I never used it except as a last resort, and, in the large majority of cases, my patients have been those upon whom other physicians had expended their skill before I was consulted. The general profession knows full well how numerous these cases are; how they baffle skill, defy medicine, and make the life of a physician anything but a bed of roses. To have at hand a remedial agent that will knock such cases out on sight, restoring nature to the normal in an incredibly short space of time, is a boon too precious to be lightly passed by. This orificial surgery has done for me in my own practice in a great number of obstinate cases.

Now, as to details, orificial surgery does not depend for its merits upon the "Great American Operation." The latter is one method used in the radical cure of hæmorrhoids, accomplishing the same work that is done by the "White head" and "clamp" operations, but doing it in a more surgical and scientific manner. It consists in the removal of the pile-bearing inch of the rectum by two circular incisions, bringing down the retracted end of the gut over the denuded surface, and making it fast again to the integument. Orificial surgery embraces any mechanical manipulation or operation found necessary to restore the orifices of the body to a normal condition.

I am well aware that the results of orificial work recorded in the various journals must sound decidedly "fishy" to those not familiar with the science. Your editorial, although evidently written in a spirit of levity, makes a very fair statement of abnormal conditions that will readily yield to orificial treatment. The cases you cite, with but one exception, have all been duplicated in my practice, and in addition I have had others even more remarkable. Two women, one from Illinois, the other from Missouri, were brought to the infirmary of which I have charge, in a state of insanity. One of these was so violent that it took four men to hold her on the table while the anæsthetic was being administered. Thorough orificial work was done in each case, and they both came from under the anæsthetic in their right minds, and in six weeks went home, sound in mind and body.

I have just dismissed a case entirely cured that is worthy of note. It was one of chronic nervous headache that had baffled the skill of the best physicians for years. The lady, having plenty of money, had tried all the watering places and consulted doctors innumerable. I placed her under an anesthetic and found the seat of her trouble in the rectum. Orificial work upon this organ removed her headache and it has showed no signs of returning, although nearly three months have passed since the operation.

I have under treatment and practically cured, a lady who has been an invalid for the past twelve years, and who has been treated by eminent physicians for "gall-stones." For nine weeks previous to the time I first saw her she had suffered from incessant vomiting which no medicines would relieve. As a last resort I went to the lower orifices, and found abnormal conditions of the rectum, urethra, cervix and uterus. These being properly treated, her vomiting ceased, and she now eats what she wants with impunity, and is steadily improving in her general health. Medicines now take effect as upon the normal system, and all is well.

But I will not weary you with further cases. You will see from what I have said that I have good reason to regard orificial surgery as my truest friend, and I can only hope that the general profession will soon adopt it in the treatment of obstinate chronic diseases, as I know of nothing that can be made of greater benefit to suffering humanity, when handled skilfully.

Most respectfully, WM. W. STEVENSON, M. D.

Medical Progress.

TOBACCO AND VISION.

In the *Med. and Surg. Reporter*, October 22nd, Dr. Dowling writes of this important subject:

Recently I have made a series of examinations of the employees of the principal tobacco factories of Cincinnati, with the same object in view.

I here give a synopsis of my findings in one hundred and fifty of these selected cases. There were altogether about 3,000 employees in these factories which I visited; about one-half of these were females, and the other half males. I found that ninety per cent. of all the males employed used tobacco in some form or other.

In my first series of examinations, some of the females were included in the list, but with the exception of the case hereafter named, none gave evidence of tobacco poisoning, as manifested by troubles of vision.

This woman, aged forty, presented a well marked case of tobacco amblyopia —she confounded the red and green colors of the test with black, and white with dark gray. She also presented a notable diminution of her visual acuteness and said her eyesight had been failing for the past two years. She had been working in tobacco for five or six years but has never used the article in any shape.

The principal colors confounded by those who were examined were red confounded with pink, dark brown or black, the latter usually in more pronounced cases; green was confounded with light blue, yellow or black. White was as a general thing confounded with gray of different degrees of intensity, according to the degree of tobacco infection. All of these cases were only affected for the central colors, in the test,—the colors in the periphery could be distinguished without much difficulty.

These subjects almost always confound colors, for central vision. First in order comes red, which is generally taken for dark brown, pink or black. Next comes green, which is mistaken for light blue or black. Then white, which appears dark gray or black. Pink looks often like blue. The peripheral vision in all these patients is generally unaffected.

Out of over 150 men examined there were forty-five who showed more or less evidence of tobacco amblyopia; the majority of these, however, were of a light degree, but thirty, however, among the number, were pretty well marked cases, as they distinctly mistook the red color of the test for brown or black, and the green color for light blue or orange, and in some instances black. They were also unable to make out the white spot in the centre of the visual field.

Persistent contraction of both pupils is usually present.

The majority of those who were examined, that is, of the whole 150, showed evidence of a contracted condition of both pupils. This was present in a good many who showed no other evidence of tobacco poisoning, but it was marked and persistent in those who showed other well marked evidence of tobacco infection.

There is almost always a gradual but progressive failure of visual acuteness in both eyes. This was noticed more or less in a large percentage of all the cases which I examined.

Thirty out of the forty-five complained of a gradual failure of vision. Three-fourths of all the men examined were over thirty-five years of age, and the oldest man examined was aged sixty-one years.

Luminous objects dazzle the eye-sight, and a bright light is found worse for reading than a subdued one. The patients see better in the evening than

at noon. In addition to this they often complain of a glimmering mist which covers all objects, especially in a bright light.

Lastly, the ophthalmoscopic examination of the eyes of those affected with tobacco amblyopia shows the papilla of the optic nerve to be more than usually red in the early part of the affection; later it appears anæmic, especially on the temporal half, and finally atrophy of the disc takes place.

It will be well to mention that all the symptoms spoken of are more marked in chewers than in smokers.

The subjects are light eaters, and the appetite is easily satisfied. A large number have decided antipathy to meat, constipation is usual, the sleep is usually disturbed, often by disagreeable dreams. They usually have to go to bed late, as they claim, in order to fall asleep. They often wake up in a few hours, and are unable to go to sleep for some time. They usually complain of more or less palpitation of the heart, and the pulse generally ranges at about 90 or over. On taking any great amount of exercise the muscles feel unusually tired, and the hand often has a characteristic tremble on holding a book or pen. A case in which this latter symptom was particularly well marked came under my treatment recently, in a man who was a heavy smoker, and had pronounced symptoms of tobacco amblyopia in addition.

When I commenced my examinations, I was under the impression that the constant inhalation of the dust and odor of the tobacco in the workshops would tend in itself to bring about symptoms of tobacco amblyopia. I am inclined to think this hardly takes place, for in my examination I found that those who did not smoke or chew were uniformly free from troubles of vision of a toxic nature and the females were almost universally free from the trouble—that is, as far as I examined them.

THE TREND OF MODERN NEUROLOGY.

We give, without desiring to endorse all their teachings. two clippings from an article by Dr. Bremer, of St. Louis, in *Gaillard's Medical Journal*, September.

EPILEPSY.

The more extensively and the more minutely, with the modern improvements of staining nerve-tissue, the brains of epileptics are examined with the microscope, the firmer becomes the conviction that epilepsy is not dependent on a molecular change only, but that the morbid state in the cerebral substance which gives rise to epileptic seizures is in many instances, probably in all, due to, if not a coarse, at any rate a demonstrable lesion. This consists in disseminated sclerotic patches, which of late have been met with in brains of patients that had suffered from "genuine" epilepsy. I myself have in two cases been able to demonstrate such sclerotic changes both in the cortex and the subcortical ganglia in the brains of persons thought to be true epileptics; those brains looked perfectly normal to the naked eye, but presented sclerotic foci on microscopical examination. Demonstrable changes, then, due to traumatism, embolism, hæmorrhage, and especially lesions of the brain in infancy, will at no distant day be recognized as the chief pathological factors in epilepsy. Even where the disease is inherited, it is probable that organic changes will be found underlying the disorder. The same is true of many cases that still are diagnosed as hysteria; and others, that are as yet called neurasthenia, will probably follow.

When we examine the text-books and the literature of neurology prior to the last decade it is astonishing what number of "functional" nervous diseases we meet with.

Thanks to the marvelous progress in the knowledge of the nature and life habits of pathogenic bacteria, we now know that the large majority of the "neuroses," erroneously so styled, are either bacterial infections or the result of tissue-changes produced by former microbic invasions of the human organism.

Thus, what was formerly called "essential spinal infantile paralysis," and after its anatomical nature had been discovered, "poliomyelitis anterior," is now without much doubt looked upon as a bacterial infection; the same is true of chorea, tetanus, some forms of neuritis, etc.

HYPNOTISM.

In determining the value of a remedial agent as a whole, we have to weigh the possibilties of its injurious and beneficent influences, and, if the former entirely overshadow the latter it is better to drop such measures. Hypnotism is of this nature. I compare it in its power for harm to the hypodermic needle. No doubt some lives have been saved by the syringe; but looking at the havoc it has wrought among the neurotics by increasing the army of morphinists, and in view of the peculiar fascination which this little instrument exerts over the nervous, and the powerful weapon it has become in the hands of the quacks, treatment of alcoholism, etc., it would be better for humanity if it never had been invented. The same holds true, only in more extended way, as regards hypnotism. While it is advisable to acquaint ourselves with the phenomena of this strange mental condition in persons who suffer from it as a disease, in the same manner as we study morbid phenomena that present themselves to us as accomplished facts, we ought not to provoke it where it is dormant. At best one affection is substituted by another, as a rule a worse one. I consider it quite complimentary to American neurologists that they have not kindly taken to this medical fad, but left its employment as a remedial agent to outsiders and those young and over-confident healers in our profession who, like Pallas Athene out of the head of Jove, jump from the medical college into practice, accomplished nerve-specialists and hypnotizers. In the vast majority of cases where it might be indicated, simple suggestion does all and even more than hypnotism, and the cultivation of sanguine temperament in the neurologist will stand very well in place of what is at best a species of mummery savoring of and leading to humbuggery. The introduction of hypnosis as such into therapeusis is, to my mind, not to be classed as progress.

Medical Items.

Red pepper tea, as hot as possible to be taken, is recommended for obstinate hiccough.

Agar is obtained from two species of Japanese algae, viz.: *Gracilaria Lichenoides* and *Gigartena-Speciosa.*

A dog hospital and dog clinic are to be established in connection with the University of Pennsylvania.—*Denver Med. Times.*

Antipyrine is reputed to possess hæmostatic properties when applied to the bleeding part in the form of a saturated aqueous solution.—*Ex.*

Sir Joseph Lister has reached the age of sixty-five, and in accordance with the rule as to age limit, has been retired from the chair of surgery at King's College Hospital.

A corner on vaccine is the latest in trusts. It was started in Moscow recently in view of a threatened epidemic of small-pox. The price of the virus was raised several thousand per cent.—*Denver Med. Times.*

Professor Kobert has discovered that peroxide of hydrogen is an antidote for hydrocyanic acid poisoning. It should be given freely by the mouth and subcutaneously until recovery or death.

Sir William Gull was asked by a lady if he did not consider experiments on animals as cruel. "Madam," he said, "there is no cruelty comparable to ignorance."—*The Humanitarian.*

St. Louis is to have two new medical journals. The *Annals of Ophthalmology and Otology* has been removed from Kansas City to St. Louis, and the *Medical Era* begins the journalistic race this month.

Among the many interesting articles in the September *Scribner* is one on "The Education of the Blind," contributed by Mrs. Frederic R. Jones. She has studied very carefully the development of the various modes of instruction, and with the illustrations gives the reader an intelligent idea of the progress of improvement in the methods of printing, writing, musical notation, etc., that have opened the outside world to the sightless.—*Ex.*

At the recent meeting of the American Orthopedic Association, held in the City of New York, September 20th, 21st and 22nd, 1892, the following officers were elected to serve for the ensuing year: President, Dr. A. J. Steele, St. Louis; Vice-Presidents, Dr. Samuel Ketch, New York, Dr. Arthur J. Gillette, St. Paul; Treasurer, Dr. A. B. Judson, New York; Secretary, Dr. John Ridlon, 34 Washington St., Chicago. The next annual meeting will be held in St. Louis, the third week in September, 1893.

The preliminary programme of the Southern Surgical and Gynæcological Association announces that the next session will be held in Louisville, Ky., on November 15, 16 and 17, 1892. W. E. B. Davis, M. D., Birmingham, Ala., is Secretary. As this is one of the very best societies in the country, and all physicians are invited to attend, we give its preliminary programme in full. *President's Address*, J. McFadden Gaston, Atlanta; *Cervicitis*, Bedford Brown, Alexandria, Va.; *Surgery of Endometritis*, A. Vander Veer, Albany, N. Y.; *Pelvic Surgery*, A. V. L. Brokaw, St. Louis; *Craniotomy on the Living*, Cornelius Kollock, Cheraw, S.C.; *Hæmatocele from Pregnancy*, W. D. Haggard, Nashville; *Fibroid and Pregnancy*, S. M. Hogan, Union Springs, Ala.; *Abdominal Pregnancy*, H. M. Coe, New York City; *Tubal Pregnancy*, Joseph Price, Philadelphia; *Kidney Operations*, G. B. Johnston, Richmond; *Inguinal Hernia*, H. O. Marcy, Boston; *Fractures*, W. C. Dugan, Louisville; *Rectal Diseases in Women*, J. M. Mathews, Louisville; *Spider Poisoning*, J. T. Wilson, Sherman, Texas; *Rapid Surgery*, Ap. Morgan Vance, Louisville; *Gynæcological Specialism*, William W. Potter, Buffalo, New York; *General Practitioner and Gynæcology*, R. M. Cunningham, Birmingham; *Morphology of Abdominal Tumors*, H. A. Kelly, Baltimore; *Modern Light on Genito-Urinary Surgery*, G. F. Lydston, Chicago; *Breast Amputations*, H. H. Grant, Louisville; *Fistulæ after Laparotomy*, J. T. Johnson, Washington, D. C.; *Shock, etc.*, Wm. C. Dabney, Univ. of Va.; *Drainage in Surgery*, A. M. Cartledge, Louisville: *Cholecystotomy*, Edwin Ricketts, Cincinnati; *Bile Stones*, W. E. C. Davis, Birmingham; *Recollections of Dr. B. W. Dudley*, Bedford Brown, Alexandria, Va.; *Intestinal Anastomosis without Mechanical Devices*, J. D. S. Davis, Birmingham.

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Original Articles.

FOREIGN BODIES IN THE CORNEA.*

BY EDWARD JACKSON, M. D.,

Professor of Diseases of the Eye in the Philadelphia Polyclinic; Surgeon to Wills Eye Hospital.

The history given by the patient, as to a foreign body in the cornea, is often worthless. If the foreign body is but partly imbedded, and the projecting portion hard and angular, so that every movement of the lid causes a scratching of the conjunctiva lining it, the patient, of course, immediately notices its presence, and can give a correct and definite history of its occurrence. But if the foreign body be deeply imbedded so that it does not touch the conjunctiva of the lid, or if it lie with a perfectly smooth surface presenting to the lid, its entrance may not be noticed, or the momentary disturbance caused by it may be so slight as to be forgotten before the secondary effects of its presence draw attention to the eye, and even if those secondary effects are ascribed to it, and the foreign body itself perceived, it may be supposed to have entered the eye at a time considerably later than was the case. Often, however, the patient will, on account of the gradual advent of the symptoms of irritation, ascribe them to an entirely different cause.

Again, very many patients come with the impression that a foreign body is in the eye, from the irritation—the sensation of scratching—caused by a simple conjunctivitis. And these, having thought the matter over carefully and repeat-

*Read before the Philadelphia County Medical Society, October 12, 1892.

edly, can usually tell just when and how the mythical foreign body was lodged there. And they even go so far as to accurately locate it, by picking out some spot on the iris not before noticed, and regarding it as the offending object.

For the diagnosis of a foreign body in the cornea we must depend on, what generally is the sufficient basis for a diagnosis in diseases of the eye, the result of our examination of the patient. If the foreign body is comparatively large the most casual glance may reveal its presence, but often there is need for special methods and a prolonged search before its presence or absence is established; and even where its presence is perfectly obvious at the first glance these same methods must often be employed to make sure that we have completed its removal.

In the search for the foreign body the important idea with reference to the illumination of the eye is that it shall be thoroughly under the control of the surgeon, so that he may either strongly illuminate the cornea itself and view it against the dark background of unilluminated iris and pupil, or can illuminate the background, leaving the cornea in comparative darkness, and depending on the interruption of the light from the background, which any opaque foreign body will cause, to reveal its location. This is the advantage that the so-called "oblique" or "focal" illumination in the dark room possesses over inspection by an ordinary diffused light.

The shifting of the point of view so as to bring the foreign body into the area of most favorable illumination is essential to any thorough search, whatever method is employed. By focal illumination foreign bodies of light color will be best seen when strongly illuminated against the black pupil as a background; while if the foreign body is dark it is better to strongly illuminate the iris behind it.

We may also get an illuminated background against which a foreign body will usually appear as a black speck by throwing the light into the eye with the ophthalmoscope mirror held several inches in front of it, and shifting the position of the eye or the point from which it is viewed so as to obtain the fundus reflex through the different parts of the cornea.

An excellent method of searching for the foreign body, and one that has the advantage of being available during its removal, is to look for the interruption that it causes in the reflex obtained from the corneal surface. To do this, place the patient facing a window with a large open sky space, while the surgeon takes his position so as to obtain the reflection of the sky space from the surface of the cornea, a very good position being to stand behind the patient, looking down on the cornea. The patient's eye is then turned from point to point, so that the reflection is obtained from all parts of the cornea in succession. If the window with clear sky space is not obtainable, a piece of plain white paper or cardboard strongly illuminated, and held close in front of the eye to be examined, will furnish the required reflex from the corneal surface. The essentials are that the reflex shall be bright, uniform, and large enough to enable the observer to go rapidly over the whole cornea without missing any part of it.

If on any part of the surface there is an irregularity, as an ulcer or a foreign

body, this will cause an interruption of the reflex, and be immediately noticeable. A great help in making such irregularities prominent is the careful drying of the cornea with a little absorbent cotton, a method to the full value of which my attention was called by our fellow member, Dr. M. W. Zimmerman. The removal of all moisture does not impair the reflex from the sound cornea, but lays bare any irregularity or loss of substance, which, when filled with fluid, would give almost the normal corneal reflex.

Another aid to the detection of foreign bodies in the cornea is the use of a solution of fluroescin. A good solution consists of,

Fluroescin	1 grain.
Sodium carbonate	2 grains.
Distilled water	1 fluidrachm.

A single drop of this is placed on the suspected cornea, and after two or three minutes the excess is allowed to be washed away by the tears. It is then found that while on the uninjured cornea not the slightest effect has been produced, the corneal tissue in the neighborhood of any recent abrasion has been stained a noticeable light green. This discoloration at once directs attention to the locality of the injury, and the stained tissue furnishes a background against which any foreign body of dark color is more readily seen.

While the reception of a foreign body in the cornea may not be noticed, and during the first few hours the pain and redness resulting from its presence are apt to be quite slight, its continued presence provokes a reaction which increases in severity until it is gotten rid of. At first the redness will be confined to the vessels of the part of the peri-corneal zone nearest the foreign body, and its location will then often guide us to the site of lodgment. Later, it extends until the whole conjunctiva and the deeper tissues of the globe become hyperæmic, when it becomes of little diagnostic value. With the increased vascularity comes increased pain and tenderness.

Of removal of foreign bodies from the cornea in general, little need be said. The introduction of cocaine as a local anæsthetic has enormously simplified it. There is, perhaps, some danger of now being led by the passive demeanor of the patient to indulge in unnecessary manipulation of the parts. The thorough cleansing of the actual cavity of lodgment, together with the scraping away of the bruised and lacerated tissue, is important, but the promiscuous scraping of the neighboring surface in the attempt to catch a foreign body that is not clearly seen is always harmful, if not dangerous.

When the foreign body enters with such force as almost to penetrate the cornea, and, to a still greater extent, when it projects into the anterior chamber, its removal becomes an operation of considerable delicacy and importance, on account of the danger of the premature escape of the aqueous humor and the scratching or puncture of the anterior capsule of the lens, casing traumatic cataract.

There applied a few months since, at the Wills Eye Hospital, a young man

who had received a small chip of iron in the center of the left cornea the day before. Efforts had been made to extract it with a piece of magnetized steel, and with a penknife, but they were unsuccessful; whether they had driven the fragment deeper I do not know. He applied in the morning, and Dr. Pontius, the resident surgeon, finding that the aqueous was escaping and the anterior chamber shallow, had, wisely, simply instilled atropine and closed the eye with a light bandage to secure rest. When the patient returned in the afternoon the swelling of the adjoining cornea had stopped the leakage of the aqueous, and the anterior chamber was of normal depth. The chip of iron was seen projecting from the posterior surface of the cornea into the anterior chamber.

The eye was placed under the full anæsthetic action of cocaine, and a broad, gradually tapering needle introduced at a little distance from the wound, in such a manner that its point entered the anterior chamber close to the foreign body and passed back of it. This point was held against the posterior surface of the cornea, the needle being steadily pressed forward sufficiently to keep the incision full and prevent the escape of aqueous. The foreign body was then dug out with another needle and the ordinary corneal spud. This was attended with the escape of some aqueous, but, with the broad needle held flat to shield it, any injury ofthe lens was prevented.

In such an operation the placing and steadily maintaining in proper position of the broad needle that acts as a shield is the most difficult part. For this purpose a needle which continues to broaden and becomes blunt and rounded on its edges, so that it ceases to act as a knife and more perfectly performs its functions as a plug, might be a slightly better instrument than the ordinary broad needle. In this case the steady maintenance of the shield-needle in position was materially aided by causing the point to reënter the posterior surface of the cornea, and by introducing it in such a direction that the tendency of the patient to move the globe kept it pressed against the needle rather than to withdraw it.

When a foreign body composed of or containing iron remains a few days in the cornea, it is apt to leave a dark-brown ring of staining when it is removed. It is often difficult to decide whether the appearance is due to this stain alone or whether some portion of the foreign body also remains. On this account it is more satisfactory to remove the stain if this can readily be done, but any prolonged or extended scraping is not justified, for the stain is harmless and temporary.

The electro-magnet is of little use in removing foreign bodies from the cornea, because they are so firmly wedged that its force is entirely insufficient to dislodge them. There is, however, a special form of foreign body for which I have resorted to the electro-cautery, namely, grains of gunpowder, which have proven when the attempt was made to extract them in the method of ordinary foreign bodies, to be so intimately associated with the adjoining corneal tissue as to render it impracticable to extract them in the ordinary way without too much laceration of tissue.

In the case of the patient shown this evening there were three such grains in the left cornea remaining after others were removed, without difficulty, from both corneas. These deeply imbedded and diffused grains were touched with a pointed electrode, and thus destroyed with the least possible damage to the surrounding tissues. The same method was applied to some of the grains that had been at the same time imbedded in the lids, brows, and cheeks, with the very satisfactory results shown.

Self-cure, in case of a foreign body in the cornea, takes place by suppuration of the adjoining tissue to such an extent that the softening loosens the foreign body and allows it to be rubbed off by the movements of the lids—a slow, painful process, that probably few persons are stolid enough to submit to without seeking competent aid for its removal. In a few cases, however, the inflammation subsides, the foreign body becoming surrounded with fibrous tissue that tolerates its presence, and in rare cases it is possible for a foreign body to remain in the cornea a long time without provoking any reaction. I have met with three cases in which foreign bodies were thus retained for periods varying from one to eighteen months.

NEW ANTISEPTICS.

Pyoktanin, methyl violet, is the most powerful antiseptic of the aniline colors.

Lysol is a saponified phenol derived from cresols, and contains the higher homologues of carbolic acid. Its antimycotic power is higher, and its poisoning effects less than carbolic acid.

Retinol is a product of pine resin—a viscid, fluid hydrocarbon, non-irritating and a staple antiseptic.

Europhen is a valuable substitute for iodoform, and has not the disagreeable odor. It contains 23 per cent. of iodide. Its chemical name is—Iso-butyl-ortho-cresyl-iodide.

Sulphaminol is a thio-oxydiph-anylasnine, and depends on its decomposition into sulphur and phenol for its antiseptic properties.

Monochlorphenol is made by the action of chlorine on phenol.

Camphoid is a spirit of camphor and pyroxylin, and a valuable, mild antiseptic.

Salipyrin. Mr. J. D. Riedel, of Berlin, has lately prepared a new chemical body known as salipyrin. It is composed of 57 parts of phenazone (antipyrine), and 43 parts of salicylic acid. It is claimed that salipyrin is free from depressing properties, and therapeutically very active.—*Pacific Medical Journal.*

LIQUEFYING GASES.

According to a report in the public press, Professor Dewar, of London, has lately produced liquid oxygen "literally by pints." The experiment was performed in his lecture room, in the presence of a large body of students. He stated that oxygen liquefies at about 250 degrees below zero, and air at 343 degrees. "If the earth were reduced to a temperature of 350 degrees below zero, it would be covered with a sea of liquid air thirty-five feet deep." Professor Dewar liquefies oxygen and nitrogen with a hundred pounds of liquid ethylene and fifty pounds of nitrous oxide, with the aid of two air-pumps and two compressors driven by steam. To pass liquid air about a room in glasses must be a startling experience.—*National Medical Review.*

PNEUMONIA TREATED BY ICE-COLD APPLICATIONS.

In the *Therap. Gazette,* October 15th, Dr. Jackson, of Brockville, Ontario, gives his experience in regard to this method. We would, however, caution our readers that dwellers in a northern climate may bear the applications much more safely than in the south. He says:

The method was as follows: A large towel was wrung out of ice-water, and the thorax enveloped in it. A comparatively dry towel was laid over it, and a binder of flannel or cotton held all snug. The ice-water towel was changed as often as necessary, in order to ease the pain and reduce the temperature. When the pain or dyspnœa was severe, or the temperature high, the intervals would be short, say five or ten minutes. As the symptoms improved, the changes were made only as the towels assumed the heat of the body. The face and limbs were frequently sponged with the ice-water, and when required a cold compress was put upon the brow.

The medication was confined to promoting a critical perspiration. This was effected by large doses of liquor ammonii acetatis and spiritus etheris nitrosi, well diluted, every hour. In one or two cases this had to be supplemented with pilocarpine muriate. No alcohol was required, except in the fatal case referred to. Antipyretics of the coal-tar series were not used, except in one case just mentioned. The diet was principally of milk, and liberal in quantity. Incidental symptoms were met as they arose. In none of the cases was there any expectoration to mention. In some none at all, in others but little. Free perspiration was usually succeeded by copious diuresis. As a precautionary measure, a wet compress was worn for twenty four hours after the crisis, and changed when it became dry.

In order to obtain the effects to be desired in this treatment, the cold must be freely applied and with a firm hand, until the effect of a reduction of temperature and arrest of symptoms occurs.

The treatment is greatful to the patient. It can be managed without incommoding the sufferer, by the exercise of a little ingenuity. It is prompt in its effects for good, and it is easily applied.

In exceedingly plethoric cases I could conceive of the value of venesection at the outset, and, in fact, have so used it with excellent effect, but not in the series under consideration.

As the experience of twenty years' continued observation, I would most earnestly deprecate the use of opium, antimony, or blisters in the treatment of pneumonia; and my experience of the more modern antipyretics is hardly more favorable.

Under the usual routine treatment of poultices, expectorants, and whiskey, I can quite understand Dr. Osler's view as to the non-efficiency of treatment. But with the experience of the free use of cold, in the manner herein outlined, and in view of the etiological considerations advanced, I feel that a new and happier era is dawning in the treatment of pneumonia.

Writing to the *Lancet,* Dr. Haig says that the depressing reaction which some persons experience after the excitement of opium has passed off may be almost completely averted by one or two doses of a salicylate.

Dr. Adami, Fellow of Jesus College, Cambridge, and formerly of Owens College and of the Manchester Royal Infirmary, England, has been appointed Professor of Pathology in the University of Montreal, Canada.

PRURITUS ANI.

In regard to this irritating disorder, Dr. Pryor, of Ocean City, Md., remarks (*Medical and Surgical Reporter*):

The treatment of this trouble is varied, every physician having his own formula; besides every case must be treated on its own merits from the conditions presented. That which I have found most successful in a considerable number of cases, is as follows: When a patient comes to consult me, I endeavor to get his confidence and inspire him with hope; the bowels are freely opened with a saline purge, or calomel, and he is directed to report for a thorough examination, when such complications as fistula, hæmorrhoids, fissure, etc., are carefully sought for. Of course when any of these are found, they each call for their respective treatment. In a simple case of pruritis ani, I order an injection of a solution of the following, which I have found to be a good antiseptic and local stimulant:

℞.—Listerine	ʒiv.
Glycerine	ʒvi.
Acid carbol.	gttxx.
Aqua	ad ʒvi.

M. Sig. ʒss. injected in rectum once daily.

It is necessary to medicate the internal sphincter and rectum in all cases of pruritis, as there is more or less irritation of these parts. I also use the different ointments and antiseptic solutions, with good results in some cases and none in others.

Lately I have employed tincture of iodine. Before using, however, I direct the patient to have the bowels thoroughly moved, and an injection of warm soap and water to be taken, the external parts to be washed and dried. Then I apply the iodine thoroughly to the diseased surface; if it is too severe, a small amount of tr. opii can be added, or the parts may be covered by vaseline protected by absorbent cotton.

After having made from four to six applications, I begin to find my patient rapidly improving, or nearly recovered. I direct him to keep the parts clean, use the injection once daily, keep the bowels open, take plenty of outdoor exercise and eat good, nutritious food. Complications, if present, must be treated according to the regular surgical methods.

MEDICAL SCHOOLS IN GREAT BRITAIN.

The Universities and Colleges of Great Britain have just entered upon their lengthened course of five years for medical students. After registration by the General Medical Council each student must pursue his medical studies *continuously* for five years before he is eligible to "go up" for his final professional examination. To be registered also requires an examination in the arts and sciences unless the candidate possesses an A. B. or A. M. degree. Having been registered, the student continues his work at some recognized hospital and college for two years, when he goes up for his first professional examination. The subjects taken up are: (*a*) chemistry, (*b*) chemical physics, (*c*) botany, (*d*) materia medica, (*e*) pharmacy, (*f*) osteology, human and comparative, (*g*) anatomy, comparative and descriptive, (*h*) physiology.

At the end of the third year the candidate, if he has passed his regular studies at his college and has been duly "signed up," may present himself for his second professional examination. This includes: (*a*) medical and surgical anatomy, (*b*) histology, (*c*) physiology and physiological chemistry, (*d*) analytical and practical

chemistry, and (*e*) "a practical acquaintance with the methods of microscopic and chemical examination is required."

After five years of continuous study and work the final or "pass" examination is taken. This includes: (*a*) principles and practice of medicine, (*b*) principles and practice of surgery, (*c*) medical and surgical anatomy, (*d*) macro- and microscopic pathology, (*e*) therapeutics, (*f*) hygiene and public health, (*g*) forensic medicine, (*h*) obstetrics and gynæcology, (*i*) physical examination of medical cases with diagnosis and prescriptions in Latin, (*j*) surgical diagnoses, cases treated and operated upon, surgical appliances, etc.

The L. R. C. P. is the lowest English qualification given by the Royal Colleges, next come the "Conjoints" of L. R. C. P. and M. R. C. S., which most candidates take, and lastly, the highest English qualification, the M. R. C. P. of London. Separate examinations are set for every one of these degrees and are all thoroughly and conscientiously conducted.

The highest degree in Surgery is the F. R. C. S. of England, for which one must pass a critical examination on technical points. For the M. R. C. P. of London one must pass in Latin and Greek and one or more of the modern languages besides English.—*Pacific Med. Jour.*

A CASE OF OPIUM POISONING.

The following case of laudanum poisoning may be interesting in connection with the case described in the *British Medical Journal* of August 27th. The patient was a frail man, 65 years of age, who was suffering from mitral regurgitation, and had been in the infirmary in 1884 suffering from paralysis of the right arm "due to cortical embolism." His intelligence was greatly impaired. On Aug. 21st he had gone to sleep in a common lodging-house. Something in his appearance attracted the suspicion of the lodging-house keepers, and an attempt was made to rouse him. As this proved futile they summoned the police, who brought the man to the infirmary shortly before midnight. An empty 4-ounce bottle, which had evidently contained laudanum, was found in his possession.

When admitted he was found to be in a condition of complete coma; the pupils were contracted to pin points, and the breath smelt strongly of laudanum. His stomach was at once washed out by Dr. Cuthbert Thomson, and then filled with strong coffee through the tube. The fluid which came away first was discolored, and smelt strongly of laudanum. As the patient seemed to be roused a little by this treatment, an attempt was made to make him walk about, but this was at once found to be hopeless. He became more and more deeply comatose; his respiration became slower, and his pulse very weak.

A hypodermic of $\frac{1}{30}$ gr. of atropine sulph. and two of 30 min. of ether were given at short intervals, and a strong faradic current applied to his extremities. This also failed to rouse him, and a little before 1 A. M. his respiration stopped altogether, and artificial respiration had to be resorted to. This had to be continued steadily till 5 A.M. before the patient showed the slightest sign of returning vitality, and it was nearly 7 before it could be done without altogether. During this time occasional injections of ether and strophanthus were administered when judged necessary.

At 7 the patient's stomach was again filled with strong coffee through the stomach tube, and by 9 he was able to tell his name. All day he continued very drowsy, but there was little difficulty in keeping him awake. At night he was rather sleepless, and talked a good deal of nonsense. He did not suffer much from exhaustion, and was dismissed from the infirmary on August 27th.—Dr. Drummond, M. B., C. M., in *Brit. Med. Jour.*

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BALTIMORE, NOVEMBER 5, 1892.

Editorial.

SYMPHYSIOTOMY.

The benefits to the human race of improvements in scientific methods of surgical work are nowhere better shown than in the reëstablishment of old methods of operation, which were advocated long ago but had been dropped, or superseded by other operations, on account of difficulties not inherent in the operation itself.

The resumption of symphysiotomy is a striking illustration of this statement. In the olden time, when our fathers were at the meridian of their careers, the suggestion was made that the cutting through of the joint of the pubic bones might secure such an increase in the capacity of the pelvis that labors, in which delivery in the natural state was impossible, might go on to a successful conclusion. But the dangers of septic infection, and distrust of the power to secure firm union, led to a disuse of the method. The objection urged by some writers that the enlargement of the pelvic canal would be of insignificant extent, seems to have been due to prejudice or to timidity in operation.

However this may be, the operation has now been taken up again with great enthusiasm by certain obstetrical workers, who claim that, under the modern antiseptic methods, the danger of sepsis does not exist; but that the operation itself is safe and simple, and that firm union of the severed parts can readily be obtained.

Already the young surgeon of Cæsarean aspirations is heard to mourn that the new operation, which may be done by any careful surgeon with ease and success, is likely to render the more striking and difficult operation still more infrequent than before. It is to be sincerely hoped that it will; and we doubt not that the young surgeon referred to will, on second thought, put his disappointment in his pocket and turn his eyes to new fields of surgical enterprise.

OUR WEEKLY CHRONICLE.

We are glad to see that the *Daily Sun* of Baltimore has taken up the matter of the pollution of Lake Roland, one of the sources of our city water supply. This matter was urged in the *Sun* a year ago by a special committee of the Clinical Society, but the editorial staff of the *Sun* did not at the time comment upon it. The cleansing of this reservoir has been strongly urged by the JOURNAL once and again during recent years.

Professor Osler, of the Johns Hopkins Hospital, has bought the house on the south-west corner of Charles and Franklin Sts., and will shortly take up his residence there.

A collection agency of this city, which ran a "black-list" for the benefit of physicians, has lately suspended business. We understand that it is deeply in debt to some of its patrons. The cause of suspension is not stated.

Reviews, Books and Pamphlets.

The Mastoid Operation: including its History, Anatomy and Pathology: by Samuel Ellsworth Allen, M. D. Small octavo, pages 111, cloth, $—; Cincinnati: Robert Clark and Co., 1892.

In the preface the author states that he lays no claim to originality; but presents to the medical public the instructions and observations received and made at the clinic of Professor Schwartze, and afterward supplemented by considerable thought and anatomical work of his own. He modestly hopes that the great importance of the subject-matter may atone for all defects in literary style.

We have been unable to detect these alleged defects, but find instead a very attractive and full account of the operative procedures referred to, with some unusually excellent illustrative plates. The printer's work is in every way first class.

We hope that both Dr. Allen and his publishers will feel encouraged to further work of equal merit.

Contributions of Physicians to English and American Literature; by ROBERT C. KENNER, A. M., M. D. Physician's Leisure Library, 1892. George S. Davis, Detroit, Michigan. Paper, 90 pages, price 25 cts.

The book covers the period from 1650 A. D. to the present date. The compositions quoted from some of the older authors sound like literal translations from German philosophy and are good as mental gymnastics. Thus Sir Thomas Browne (1605-1682) writes: "Restless inquietude for the diuturnity of our memories unto present considerations, seems a vanity almost out of date and uperannuated piece of folly." "To extend our memories by monuments, whose death we daily pray for, and whose duration we cannot hope without injury to our expectations, in the advent of the last day, were a contradiction to our beliefs." "To weep into stones are fables. Afflictions induce callosities."

There are many poetical bits from physician-poets, very beautiful no doubt, but somewhat fatiguing to modern readers. We are greatly relieved to find the close of the volume aglow with the humor and beauty of Dr. Holmes' muse. The selections from his poems, one of the best of which, "The Stethoscope Song," we have not seen before, are in themselves almost worth the purchase of the little book.

Diseases of the Kidneys and Bladder; a Text-Book for Students of Medicine; by W. F. McNutt, M. D., M. R. C. S. Ed., L. R. C. P. Ed., Professor of the Principles and Practice of Medicine, University of California; Professor of Diseases of the Kidneys and Heart, Post-Graduate Department of the University of California, etc. Philadelphia: J. B. Lippincott Co., 1893(?). Octavo, cloth, $2.50; pages 242.

This book is based upon notes of the lectures delivered to the medical students of the University of California. It exhibits both the excellencies and the defects of an elaboration of a lecture-series—the excellencies, in that it has a pleasant attractive diction and preserves the flavor of personal experience—the defects, in that it lacks deep research into the latest literature. We can recommend it as a desirable book of reference for the office-shelf; but we cannot endorse as a text-book a work on Diseases of the Kidney which omits all mention of sugar-tests, while giving a chapter 14 pages long on diabetes mellitus. We hope that this omission may be corrected in a future edition, for the book has many excellent points. The work of the publishers is, as usual, in every way satisfactory.

The American Chemical Journal for October presents a number of papers on laboratory work including a study of the "carbohydrates of the coffee berry;" all of which belong to the purely scientific side of chemistry.

The Alienist and Neurologist for October (1892) contains: "Clinical Study on Double Athetosis," by Dr. Dimitri Ivan Michaïlowski, Russia; "Sentiment," by Professor Augusto Tebaldi, Padua, Italy; "Passivism—A Variety of Sexual Perversion," by Dimitry Stefanowski, Jaroslawl, Russia; "The Pathological State of Berkman, the Assailant of H. C. Frick," by Theodore Diller, M. D., Pittsburgh, Pa.; "Experts and Expert Testimony," by Harold N. Moyer, M. D., of Chicago, Ill.; "A Case of Simulated Insanity," by Professor Arrigo Tamassia, Russia; "Art in the Insane," by James G. Kiernan," M. D., Chicago, Ill.; "A Case of Cerebral Syphilis," by Frank G. Hoyt, M. D., St. Joseph, Mo.; "Torquato Tasso," by Dr. W. W. Ireland, Scotland.

Besides these are the usual selections, editorials, hospital notes, reviews, etc. C. H. Hughes, M. D., Editor, 500 N. Jefferson Ave., St. Louis. Subscription: $5.00 per annum; single copies, $1.50.

Medical Progress.

COMPLICATED FRACTURES.

The following is from the description given in an editorial of the *Med. and Surg. Reporter*, Oct. 29th, of von Volkmann's treatment at his clinic: In the absence of much contusion to the soft parts, the wound is cleansed and disinfected, then powdered with iodoform, and dressed with iodoform and sublimate gauze.

If injury to the soft parts has deprived them of their vitality, such are removed, the wound washed out with sublimate solution and, if necessary, provision made for drainage.

Incision is only resorted to when there is reason to believe that foreign bodies have entered the wound, or the fracture has perforated into an articulation, or if symptoms of local infection present themselves.

As a rule bone sutures are not used; when, however, it becomes necessary, use such. Metal wire or Gussenbauer's clamps are used.

CARCINOMA OF THE MAMMA.

In the *British Medical Journal*, September 24, are stated the conclusions of Dr. Stiles, Assistant to the Professor of Surgery, University of Edinburgh, on this important subject. We may quote portions of these conclusions as follows:

1. That the cancer in about 90 per cent. of the cases assumed the form of a single, non-encapsulated, clearly defined, but microscopically infiltrating tumor.

2. That although the naked eye appearances of the tumors varied considerably, their histological structure was essentially the same in all, consisting, that is, of clusters of modified epithelial cells situated in the lymph spaces and lymphatic vessels of a vascular connective tissue stroma.

3. That the epithelial elements of the tumor differed so widely from the ephithelial cells of the adjacent and surrounding gland parenchyma that the old term "cancer cells" might with advantage be applied to them. In properly prepared sections the two kinds of cells, when viewed in the same field, might readily be distinguished from one another. The cancer cell might contain one or more leucocytes in its interior and sometimes the whole cell appeared to have been destroyed by leucocytes.

4. That the stroma of the tumor consisted partly of the pre-existing tissue and partly of a newly-formed tissue, the result of an inflammatory connective tissue hyperplasia, which was secondary to the irritation produced by the cancer cells. In the meshes of the stroma were leucocytes more or less numerous.

5. That the cancer cells lay loose in the tissue spaces of the stroma, and were therefore liable to be washed into the lymphatics by the lymph stream. Probably they possessed a certain degree of independent movement.

6. That the duct and intracystic epithelial papillomata which were sometimes met with in the breast, especially in connection with chronic inflammatory affections, were epithelial hyperplasias, which were secondary to a vascular and connective tissues hyperplasia. Such epithelial hyperplasias were to be distinguished from carcinoma, not only microscopically, but also clinically, since they do not, as far as he was aware, give rise to secondary growths in the lymphatic glands and internal organs.

7. In addition to the primary tumor, which represented the primary focus of disease, secondary cancerous foci made their appearance sooner or later; they were more or less numerous and extensive in different cases. When numerous, extensive, and of early origin they might give rise to a cancerous infiltration of the entire gland, and produce what was termed a "diffuse carcinoma." Carcinoma of the mamma, originating as a cancerous transformation of the entire gland paranchyma, rarely, if ever, occurred.

8. That the secondary cancerous foci, which were found in the extrinsic tissues of the mamma, were due to lymphatic dissemination of cancer cells, derived more or less directly from the primary tumor. No spermatic influence was exerted by these cancer cells upon the cells proper to the tissues in which they lay, so that the latter were never transformed into cancer cells.

9. The smaller cancerous foci which were occasionally found in the breast tissue, more or less distant from the main tumor, appeared also, as far as his observations went, to be the result of lymphatic dissemination of the pre-existing cancer cells, rather than to arise as independent foci. Cancer originating in the form of multiple foci was as rare in the mamma as it was elsewhere in the body.

10. Those lobules of the parenchyma which were about to be invaded by the cancer were at first the seat of an inflammatory reaction, which might be either

acute or chronic. When acute, the lobule was infiltrated with leucocytes. Ultimately the adjacent cancer cells invaded the substance of the lobule, and completed the destruction, already begun by the leucocytes. When the reaction was chronic, hyperplasia of the interacinous connective tissue occurred, and gave rise to a certain amount of proliferation of the epithelial cells of the acini, which, however, was not of a cancerous nature.

11. Various conditions of the parenchyma were met with here and there throughout the gland in carcinomatous mammæ. In many instances the parenchyma appeared to be perfectly normal. In others, again, catarrhal changes, plugging of ducts with degenerated products, cystic changes, and interstitial inflammation were met with. After inquiring carefully into the clinical histories of all the carcinomata he had examined, Mr. Stiles had not been able to trace any special etiological relationship between mastitis and carcinoma.

12. By the *nitric acid method* he had shown that the gland parenchyma extended much further in all directions than was generally supposed, and that the surgeon frequently fell short of his intention to remove the entire breast. The principle which should underlie all operations for carcinoma of the mamma should be the complete removal, not only of the tumor and of the breast, but also of as much of the surrounding tissues as was likely to contain the lymphatic spaces and highways along which the malignant elements of the disease had been disseminated.

CONSTIPATION.

In the *Doctor's Weekly*, October 29th, we find an interesting article by Dr. Currier upon this subject from which we clip a few paragraphs:

A study of the histories of one hundred consecutive cases in the records of his private practice showed that in sixty-five there was manifest and annoying constipation. All of these cases consulted him with reference to pelvic disease, either complicated or uncomplicated with disease of other parts of the body, and the diagnosis included almost every recognized form of disease or lesion of the pelvic organs. Dr. Currier said he would define constipation as simply that condition in which the intestine fails to readily expel the excrementitious matter which it contains at intervals sufficiently frequent and in a mass of suitable consistency to ensue the individual against detriment from waste and decomposing material. Any cause which impairs the activity of the voluntary or involuntary muscles concerned in the act of defecation, will tend to produce constipation. Such causes may be removable or irremovable. Of all the preventable or removable causes from which constipation in women originates, neglect or indolence is the most common. It is most noticeable in girls and young women; it is less noteworthy in mature women and least apparent in the aged. Under ordinary conditions the inclination to evacuate the bowels is caused by the deposit of fæcal matter within the rectum, the mucous membrane being excited or irritated by its presence. Hence there is reason in the statement which is to be found in the text-books on physiology that the rectum is usually empty. It has been the speaker's experience, however, that the rectum of women is rarely free from fæcal matter, excepting after particular preparation, and the insensitiveness which accompanies it has much to do with the constipated habit. Constipation in both sexes is a common occurrence as the result of disease above the pelvis, but certain forms of such disease occur much more frequently in women than in men. Peritonitis may serve as an illustration of a condition which is especially common after abdominal operations and with disease of the pelvic viscera.

The causes which are operative in the production of paralysis of the bowel

above the pelvis are similarly operative and to a much greater extent on that portion which is within the pelvis. These causes may be considered with reference to the treatment which is usually employed for their relief; that is, from a medical and surgical standpoint. In the former are to be included the thickenings and new formations of syphilitic origin, the dilatation and muscular weakness accompanying prolonged inattention to the accumulation of fæcal matter, as in certain cerebral and spinal diseases, congestion and engorgement of the venous system associated with menstruation or pregnancy, or obstruction in the portal circulation. From the surgical standpoint, causative conditions are to be found in fissures, ulcers and hæmorrhoids, polypi, infiltration of the tissue with malignant or inflammatory disease, dilatation and weakness due to prolapse of the vagina, or rupture of the perineum, or both. The disposition of the viscera in the female pelvis is such as to make constipation possible if the normal arrangement is but slightly disturbed.

TOXICITY OF THE SERUM IN CASES OF ECLAMPSIA.

Puerperal convulsions are now generally regarded as the outcome of autointoxication. Bouchard has demonstrated the lessened toxicity of the urine passed, often only in diminished quantity, by such patients. It occurred to Dr. Chambrelent, of Paris, to supplement these observations of Bouchard by examining the serum of the blood drawn during the attacks. Taking as a basis the fact already established by Rummo that 10 cubic centimeters of healthy human serum is the quantity necessary to kill one kilogramme of rabbit—*i. e.*, 10 cc. to each kilogramme of body-weight—he found that this degree of toxicity was greatly exceeded when eclamptic serum was employed, and that there was a constant relation between the poisonous properties of the serum and the gravity of the case. Six patients were the subjects of the above experiments at the Obstetric Clinic of the Paris Faculty.—Paris correspondence of *Lancet*.

TETANUS, RECOVERY.

In the *Lancet* of September 24, Dr. Cholmeley reports a case of a child seven years of age who had run a small but dirty splinter of wood into the palm of his right hand about three weeks previously. The small wound had not healed up properly, but remained in an unhealthy-looking condition; a few small vesicles of watery pus occasionally formed around it. On July 18th his parents noticed that his face was apparently drawn to the right side, but as he did not seem ill he was allowed to go to school, where he was able to join in the play as well as the work and showed no symptoms of illness. On the following night he was convulsed several times, but was better in the morning and again attended school. At night the convulsions returned and he could only open his mouth a little way owing to the continued muscular spasms.

When admitted to the hospital two days later the boy was said to have taken no food for the previous forty-eight hours. His jaws were firmly fixed, his whole body was rigid and he could only just stand. His back was arched, his abdomen as hard as a board, his head retracted, the features drawn into a grin, but he did not complain of actual pain. Attempts to feed him with a tube only resulted in still more violent spasm, the whole body being thrown into the position of opisthotonos. The spasm was, indeed, so severe that the respiration nearly ceased, the patient becoming rapidly livid. Chloroform was at once administered and the spasm passed away under complete anæsthesia. The jaw could then be opened and, a gag being inserted, the mouth was explored, but nothing abnormal discovered, with the exception of a pellet of chewed paper at

the back of the tongue. By means of a nasal tube a mixture of milk, beef-tea, yelk of egg and brandy was passed into the stomach and retained, and fifteen grains of chloral hydrate were given in the same way. The child slept well for several hours, the spasm of the abdomen and limbs being quite relaxed and that of the jaw nearly so. On waking, the boy seemed quite conscious but drowsy, and an attempt to feed him in the ordinary way was made, but only with the result of producing recurrence of the spasm and the necessity for the further use of chloroform. Vomiting occurred once, and for the moment the jaw spasm was relaxed, but rapidly came on again. The spasm of the trunk muscles was unaffected. There was no relaxation of sphincters.

On the second day after admission it was found possible to feed by the mouth by sips sucked through the teeth, but this improvement did not last long, and again the feeding tube had to be resorted to under chloroform and large doses of chloral administered, doses varying from ten to fifteen grains being given at longer or shorter intervals as the severity of the spasms required. This condition continued until July 31st, the child becoming very thin, the superficial veins of the trunk being very prominent and general cyanosis coming on at intervals. The pulse remained fair; the temperature never rose above 99° and the bowels acted. Steady improvement began to be noticed during the first week in August, and by degrees the general muscular spasm and finally the spasm of the jaw completely passed away and the use of the chloral could be suspended with safety. The patient made an excellent and complete recovery.

IMPROVEMENT IN OPERATION FOR HYDATID CYST.

In the *Brit. Med. Jour.*, Dr. Stephen, of Cyprus, writes thus:

By the operation for hydatid cyst is meant that procedure which I take it for granted is now the generally accepted surgical treatment of such a cyst, namely, to cut down on the cyst or the organ which contains the cyst; and if it be in the abdominal cavity, establish complete adhesion, preferably by sutures, between the parietal peritoneum and that covering the cyst or cyst-containing organ; then, either immediately or after an interval of a few days, to cut boldly into the tumor and establish free drainage.

There are no particular dangers or difficulties in this operation beyond those that are contingent upon any procedure which may involve laying open the peritoneal sac; but in the after-treatment considerable danger is not unlikely to arise, for asepsis is not easy to maintain. It is to avoid this danger in the after-treatment that my improvement is directed and the method of carrying it out is as follows:

After exposing the cyst, and allowing sufficient time to elapse both for firm adhesions to form—to obtain these I use multiple sutures of fine sterilized silk—and for the flesh wound to cover itself with protective granulations, open the cyst as freely as the flesh wound will allow; then with the forefinger slightly push the ectocyst from the surrounding tissue, and along the finger slide a metal tube connected with an irrigator, held about 8 feet from the ground, and filled with twice-boiled water, of a temperature of not less than 105° to 110° F. The force of the water falling from this height completely detatches the ectocyst and forces it, whole and untorn, out of the wound. When the ectocyst is evacuated, continue to irrigate, gently smoothing the tube over the whole surface of the false cyst until all the shreds of lowly-organized fibrous tissue which united the true and false cysts have been driven out of the wound and the stream of water returns perfectly clean and clear. Dress with dry mercury cotton-wool. The

metal tube which I use is simply a full-sized silver catheter with the end filed off at an angle.

I have not yet had a sufficient number of cases to make a fair comparison between the results from this method and those of simple incision and more or less incomplete removal of the very easily torn cyst; but it is evident that a method which secures the complete removal of the whole cyst, of every drop of hydatid fluid, and of all shreds of the false cyst which are likely to die, and leaves nothing but a perfectly clean cavity, must necessarily greatly lessen the chances of subsequent septic inflammation.

In conclusion, I am sufficiently grateful to note that, though the above method is original in its object and application to hydatid cyst, the idea was given to me by part of the procedure detailed by Mr. A. E. Barker for the cure of psoas abscess without drainage.

FRACTURE OF BASE OF THE SKULL WITHOUT INJURY TO THE BRAIN.

In a recent number of the *Lancet*, Dr. Mothersole reports the two following cases seen in the Liverpool Northern Hospital in 1890.

The first case was reported to me in the *Guy's Hospital Gazette* for 1890, in order to emphasize the distinction between fractured base with and without brain injury. A robust man about forty had a heavy cask roll on his head as he lay on the ground. If he lost consciousness at all it was only for a few seconds. On admission to the hospital there was bleeding from both ears; that from the left soon ceased, but the right continued to bleed for twenty-four hours. From the position of cuts and bruising on the sides of his head it appeared to have been "nipped" in the bi-temporal diameter. In three days' time facial paralysis appeared on the left side. He declared all along that there was nothing much the matter with him, and was with difficulty persuaded to remain in the hospital even for a week. In this case there seems certainly to have been a fracture through the left petrous portion, and the copious hæmorrhage from the right ear makes it probable that a transverse fissure extended right across the base of the skull.

The second case occurred a few weeks later. R. B—, a man of forty-seven, was admitted on September 8th, 1890. While taking a barrel of whiskey down a flight of steps, descending backwards and steadying the barrel with his knees, he slipped and fell forward against the steps, the barrel rolling over his head. He did not lose consciousness. On admission into the hospital he had some cuts on his nose and forehead, with fracture of the nasal bones; there was no hæmorrhage from either ear. Next day a copious discharge of clear serous fluid came on from the left ear, containing a small proportion of albumen. On the 10th a considerable quantity of clear, colorless fluid continued to drain away. On the 12th his temperature, which had been 100° the previous night, rose to 101.6°, and he had an attack of vomiting at 10 A. M. Towards noon he was alternately drowsy and restless, and his speech was somewhat incoherent; the discharge from the ear had almost ceased. He was placed in a dark, quiet room, and his diet was reduced from two pints to half a pint of milk per diem. At 1 P. M. twitching of the left leg and right arm was noticed, but in the evening his temperature fell to 101° and he became quite sensible. For two or three days he complained of pain in the head, and on September 15th paresis of the left facial muscles was observed. From that time he improved steadily, and left the hospital on October 11th apparently quite well except for slight weakness of the muscles on the left side of his face.

Although these two cases may be considered rather trivial to be reported

they illustrate very well how the base of the skull may be cracked without injury to its contents. The second patient would appear to have had a slight attack of simple aseptic meningitis.

FREE FLUID IN THE ABDOMINAL CAVITY OF THE FEMALE.

In reporting several cases in which the effusion was of the variety not (generally speaking) attended with anasarca elsewhere, Dr. Oliver remarks:

In the majority of cases the fluid which is found free in the abdominal cavity resembles the normal transudations of the body. Occasionally, however, it differs from dilute liquor sanguinis as it may be poured out by the rupturing of some cyst or abscess or the bursting of one or more blood-vessels. From the peritoneal sac of a well-fed animal, especially after the ingestion of a good meal, one is able to collect a quantity of serous fluid. Under ordinary circumstances, however, the arterial and venous pressures are so regulated that this liquid does accumulate, but forthwith it finds its way again into the blood through the lymphatics. When therefore dropsy of the peritoneum occurs we may practically consider it as resulting in consequence of some derangement of a physiological phenomenon. The capillary system we know is the seat of the phenomena of nutrition, absorption and secretion, and it is to this system we must look for an explanation of the manner in which dropsy of the peritoneum takes place. If in a healthy animal we ligature the principal vein of the limb it does not follow that by thus interfering with the return of the blood we shall produce œdema of this extremity. When, however, we cut the vaso-motor nerves, the interstitial meshes of the area so disturbed are forthwith more or less markedly infiltrated by a serous exudation. In this case we destroy that tone of the vessels which is so essential for the maintenance of those physico-vital processes which are for ever going on, and by so doing we favor not only the transudation of serum, but interfere with the rate of absorption. Dropsy of the peritoneum very frequently depends upon inflammatory disease of the kidneys or upon organic disease of the lungs or heart. In this group of cases it is but a portion of a general dropsy, as the universal areolar tissue is similarly infiltrated.—*Lancet.*

RECOVERY FROM VALVULAR DISEASE OF THE HEART.

In the *Lancet*, September 24th, Dr. Lindsay, of Belfast, Ireland, after giving an analysis of five cases of valvular disease of the heart, nearly all in adults, says:

There seems no doubt that occasionally, though rarely, organic valvular disease may entirely disappear. The best observers are agreed upon this point. There is no doubt whatever that the cardiac murmurs often present in chorea very frequently disappear, and everything seems to point to the conclusion that these murmurs are organic and not functional. The topic of prognosis in valvular affections naturally suggests the question whether any of the subjects of this affection may be fitly passed for life insurance at some increased premium. Most offices refuse positively to accept any applicant who has any form of cardiac disease; but this is not an absolutely universal rule and the point may arise with any of us. Sir Andrew Clark and Dr. Clifford Allbutt are both of opinion that certain cases in the class under consideration may be safely selected for insurance at some heavy increase of premium. The cases recommended for such a course are such as those previously described as affording grounds for a hopeful prognosis. Cases of mitral regurgitation, which have remained *in statu quo* for several years, where there is no change in the ventricle, no accentuation of the pulmonic second sound, no evidence of embarrassed circulation, and no subjective symptoms, are suggested

as fair subjects for insurance at certain rates. Dr. Clifford Allbutt advises that such cases, if accepted, should be put upon the early payment system, so that all the premiums should be paid by the age of thirty or thirty-five. I confess I should hardly feel at liberty at present to recommend for insurance any applicant who presented the signs of organic valvular disease of the heart, though I have little doubt that there will, in the early future, be such an advance in precision of prognosis as to permit of this being done in a manner equitable alike to applicants and to the insurance companies.

CONSTIPATION IN INFANTS.

At a recent discussion in the Medical Society of the County of New York, Dr. Emmett L. Holt, of that city (*Doctor's Weekly*), remarked that there was one point which seemed to him to be worthy of more consideration than has been given to it in the treatment of constipation in very young children, where it is almost as troublesome as in women. We have all found that one class of children are never constipated, and that is, those who are nursing at the mother's breast or who have a good wet-nurse. In such children, the percentage of fat in the feces is much larger than has hitherto been appreciated; about thirty per cent. of the solid ingredients is composed of fat. Another class of young infants are always constipated, and those are generally the infants of women who are delicate and anæmic, or where the supply of milk is scanty. This is also the case with infants who are fed with cow's milk. In all these cases where constipation exists, he has found by experiment that the milk does not contain sufficient fat. The amount of fat in the milk should be about five and one-half per cent. In bottle-fed infants cream could be added to the milk, and this gives us the very best laxative for little children and one which will be found efficient in four cases out of five.

LABURNUM POISONING.

In discussing the desirability of the possession by the children of the poor of some knowledge of the names and properties of common flowers and weeds, an editorial in the *Lancet* says:

The other day five children narrowly escaped poisoning by eating the seed-pods of laburnum, and almost in the same breath we hear of fifty-eight boys in an industrial school in the south of England chewing laburnum roots for stick liquorice, and shortly thereafter being treated in a hospital for the symptoms of narcotic poisoning. A garland of laburnum flowers worn round the neck is said to produce headache, and a correspondent tells us of a boy mistaking and eating laburnum seeds for green peas, with the result that but for prompt medical intervention he would have died.

HYPERTROPHY OF THE MUCOUS MEMBRANE OF THE UPPER LIP.

A male inmate of Broadmoor Asylum drew my attention to the existence of a small pendulous growth arising from the inner surface of his upper lip, a little to the left of the frænum and extending in an outward direction for the space of about an inch. The growth was not noticeable when the lips were closed, but presented a somewhat unsightly appearance when the patient spoke or laughed. It had been slowly increasing in size and latterly had become a source of annoyance to him during mastication. Previous to his admission here he tells me he had been troubled with a similar growth in the same situation, which he removed himself with a pair of scissors. A cure, however, was not effected, since, very soon after the wound had healed, the growth again began to make its appearance, and had now become troublesome in the respect I have mentioned.

Recognizing the case to be one of hypertrophy of the mucous membrane, from the nodular and shotty character of the contents of the tumor, I decided upon removing it with the knife. This I did by means of an incision carried round the base of the tumor, taking care not to encroach upon the free margin of the lip. Having removed the superabundant tissue, I noticed several small yellowish-white bodies about the sizeof a split pea (the hypertrophied labial glands) scattered over the surface of the wound. These I removed carefully by means of a pair of dissecting forceps and then closed the wound with horsehair sutures. The wound healed by first intention, leaving no deformity, and although it is now some months since the operation there is no sign of a recurrence of the growth. Mr. Bryant has shown that this hypertrophy is due to an overgrowth of the labial glands and that unless these are all removed the growth is likely to recur. When my patient performed the operation on himself several of the hypertrophied glands must have escaped removal, and I have no doubt it is to this fact that the recurrence of the growth *in situ* is to be attributed.—Dr. Miles, *Lancet.*

TAXIS FOR HERNIA.

From an article in the *Lancet* of August 20, by Dr. William H. Bennett, on the dangers attending the reduction of strangulated hernias, we extract two paragraphs:

1. *The mode of applying taxis.*—This may appear such a purely elementary point as to render its consideration hardly justifiable outside the student's text-book. It is nevertheless true that practitioners, otherwise intelligent and trustworthy, do at times manipulate a hernia in the manner best calculated to cause injury to the contents of the sac, whilst it affords the least possible chance of effecting reduction. I do not propose to occupy time now with a description of the method by which the taxis may be applied safely and with fair prospect of success, as it can be more usefully learnt from practical demonstration at the bedside, but some of the details of the process are so important and essential that they require a passing notice. The details referred to are as follows: (*a*) All manipulations should be conducted only with thoroughly warm hands; (*b*) the neck of the hernia should be firmly supported by one hand whilst the other manipulates the body of the tumor. (*c*) In using the fingers all pressure from the finger-ends should be made by *the front of the digital pad and never by the actual tips.* (*d*) The pressure necessary in the manipulations should be gentle, firm and regular, not forcible, unsteady and spasmodic. The necessity for warm hands, for the support afforded to the neck of the hernia, and for the avoidance of the use of the actual finger tips, is, I cannot help feeling, not so universally acknowledged as it certainly should be, for I have more than once seen attempts made at the reduction of a rupture by grasping the body of the tumor with hands almost blue with cold, the neck of the hernia being left entirely unsupported, and then with a punching and rolling movement, during which the finger tips have been deeply pressed into the parts, the force has been gradually increased until further persistence in the attempt has been rendered impracticable by the protests of the patient. Where injury is possible it is from some such faulty plan as this that it is most likely to result. The cold hands excite every resistance in the way of muscular action; the want of support to the neck of the hernia makes its reduction very unlikely by allowing the gut to bulge over the margins of the constricting ring, and, beyond this, in neglected or long-standing cases, when the bowel has commenced to ulcerate from within, the pressure of the sharp edges of the stricture acts as a great advantage in further injuring and perhaps bursting the thinned and weakened intestinal walls. Finally the sharply indenting

finger tips are admirably adapted for causing an unnecessary amount of bruising and possibly laceration of the gut.

2. *The time which should be occupied in taxis.*—Judging from my own experience, and from what I have seen in the practice of others, five minutes should be taken as the outside limit during which manipulation of a hernia in cases of apparent strangulation, or when the impulse on coughing is absent, may be with safety persisted in, no matter how gently it is applied. In unstrangulated cases the same time should always be considered as sufficient, for, although no actual harm need result, if the time be extended it may very easily produce it; moreover, if success is not attained by the end of five minutes it is very unlikely to result at all, and further attempts are practically useless.

Recommendations of Therapeutic Agents.

Among the new surgical dressings europhen seems to have quietly taken an elevated position as a positive and complete substitute for iodoform. It seems probable from recent investigations that we must rely upon some form or combination of iodine in order to secure a perfect, local antisepsis. The chief of these lie in the fact that the iodine component of europhen is given off slowly, thus presenting fresh, nascent iodine to the tissues, and maintaining the healing processes. A further advantage in this slow development of iodine is, that it prevents the possibility of irritant or toxic action. This is why large denuded surfaces, like burns or scalds, may be fully covered with it, and not give rise to any untoward effect. Europhen, in fact, appears to be especially adapted to extensive lesions, since its covering power is five times greater than that of iodoform, while its odor, though faint, is sufficiently well characterized to neutralize the peculiarly disagreable fragrance attached to all surgical dressings. We note that recent clinical articles in approval of europhen in the dermatoses, traumatism and ulcerations, as also in specific lesions, have been written by Drs. Allen, Chappell, Shoemaker, Giles, Fernandez, Gilbert, Fichler and others, who have extended the uses of europhen to ophthalmology, gynæcology and rhinology as well as the needs of minor and general surgery.

Medical Items.

Kobert's alkaloid obtained from ergot (Cornutinum) is reported by Gehe to be more and more in demand.

The *Ontario Medical Journal* is a new medical monthly published in Toronto and edited by Dr. Orr, of that city.

Eugene L. Crutchfield, M. D., F. S. Sc., Lond., has been appointed Lecturer on Applied Therapeutics in the Baltimore University, School of Medicine, to begin his course of lectures this month.

Professor Virchow's friends recently celebrated the twenty-fifth anniversary of his first election to the Prussian Parliament, in which he still represents the Third Berlin Constituency.

The German Anthropological Congress will hold its next (twenty-fourth) annual meeting at Hanover in 1893. Professor Virchow has been chosen President, with Professors Waldeyer and Schaafhausen as Vice-Presidents.

The *Lancet* considers the rushes which are made upon banks reported unstable as a symptom of insanity.

A case is reported from Russia in which a child of three months presented marked symptoms of carbolic acid poisoning, after spending a few hours in a room which had just previously been disinfected with a two per cent. carbolic acid spray.

A Brooklyn drug clerk sold twelve pills, each containing one-half grain of santonin, to a woman who wanted vermifuge for her two year old boy. She gave the boy all the pills at once, and he promptly died. This only adds one more to the long list of deaths caused by the culpable carelessness of drug clerks in prescribing poisonous drugs.—*Ex.*

Dr. Vulpian states that salicylate of lithia is more efficacious than salicylate of soda in cases of acute and progressive subacute articular rheumatism; it also has some effect in chronic cases when a certain number of the joints are still deformed and painful.—*St. Louis Clinique.*

Chloral hydrate is promptly decomposed by alkalies, with the production of chloroform. Combinations of chloral with alkaline salts or adjuvants should therefore be avoided. In this connection, note should be made of the fact that alkalies concealed in preparations, such as aromatic spirit of ammonia, may creep in unnoticed and do mischief.—Dr. Fink, *Ex.*

A full chair of Pathology has been instituted in McGill University, and J. G. Adami, M. A., M. B., has been appointed professor of this subject. Dr. Adami has for some time acted as Demonstrator of Pathology in Cambridge University. He is recognized as one of the leading younger English pathologists. McGill University is to be congratulated in having secured the services of a man so fully competent to fill about the most important chair connected with the Medical Faculty.—*Ex.*

A number of the *Mährisches Tageblatt* reports upon a case of poisoning which occurred with the new anæsthetic, "pental." A local dentist, Dr. Horny, intended to narcotize a lady with this agent for the purpose of extracting a tooth; the subject had not consumed half of the allotted quantity when the dentist observed signs of collapse. The patient had sunk into profound coma, which it was impossible to overcome with all available animation and stimulant measures. The physicians called in could only confirm the patient's death.—*Ex.*

Dr. B. A. Gould, President of the American Metrological Society, writes from Germany that at the quinquennial session of the Geographical International Congress held in Berne, August 10th–17th, there were about 280 delegates and representatives from all countries. At this Congress was passed the following resolution on August 14th: "The Geographical Congress entreats Englishmen of science to desist in future from the use of their ancient units of weight and measure in scientific and technical publications, and to employ those of the metric system only." This resolution was passed with immense enthusiasm; the applause and cheering lasted for nearly five minutes, and the vote was unanimous.—*Ex.*

Dr. A.A. Smith, of New York, recently remarked in a society discussion (*Doctor's Weekly*) that some years ago he devised a wooden roller, with a handle which was to take the place of massage in treating cases of chronic constipation;

he soon found that it was open to grave objections, because the amount of pressure could not be accurately regulated. He recently saw a woman who had been advised by a European physician to use a cannon-ball for the same purpose. The cannon-ball he had given her weighed about six and one-half pounds. Dr. Smith showed a cannon-ball weighing about four and one-half pounds, and covered with soft padding, which he had made. This ball is rolled over the abdomen, following the course of the colon.

The following papers are announced for the semi-annual Faculty meeting at Easton, Md.: The Amœba Coli, W. T. Howard Jr.; Club-foot (Illustrated), W.B. Platt; Deflection of Nasal Septum, John N. Mackenzie; Nasal Stenosis. S. K. Merrick; Ciliary Wounds causing Cataract, R. L. Randolph; Causes of Earache, Hiram Woods; Therapy of Galvanic Current, A. K. Bond; Successful Colotomy, S. T. Earle; Complications of Phthisis, W. B. Canfield; Localization of Brain Tumor, George J. Preston; Antisepsis in General Practice, W. Frank Hines; Laparotomy for Ectopic Pregnancy, J. E. Michael; Genital Tuberculosis in Woman, J. Whitridge Williams; Ovariotomy and Hysterectomy, Robert T. Wilson; Relation of Female Organs to Cerebro-Spinal Disturbances, T. A. Ashby; Hysteromyomectomy, Hunter Robb.

There is danger of being over-zealous in guarding against incompatibilities. A Philadelphia physician recently wrote a prescription for a 3 ounce mixture containing, together with other ingredients, potassium bromide 2 ounces and morphine sulphate 1½ grains; of this the patient was directed to take two teaspoonfuls in water every two hours. The prescription was sent to a local pharmacy, but the clerk refused to compound the medicine, remarking openly that "it would poison her." When the physician called for an explanation, the clerk stated that he had refused to compound the medicine prescribed because "it would be likely to form an insoluble morphine hydrobromate, which would poison the patient." Thereupon the physician sued the druggist for $20,500, to make good the loss of two patients and the damage done his professional reputation by the declarations of the clerk. The druggist was upheld by the Court, who deemed it wise to encourage caution on the part of dispensing pharmacists.—Dr. Fink, *Bulletin of Pharmacy.*

The *National Druggist* quotes Henry George's opinion of the propriety and justice of the druggist's charges: "When I go to a druggist's and buy a small quantity of medicine or chemicals, I pay many times the original cost of these articles, but what I thus pay is in much larger degree wages than profit. Out of such small sales the druggist must get not only the cost of what he sells me, with other costs incidental to the business, but also payment for his services. These services consist not only in the actual exertion of giving me what I want, but in waiting there is readiness to serve me when I choose to come. In the price of what he sells me he makes a charge for what printers call "waiting time." And he must manifestly not merely charge waiting time for himself, but also for the stock of many different things only occasionally called for, which he must keep on hand. He has been waiting there with his stock in anticipation of the fact that such persons as myself, in sudden need of some small quantities of drugs or chemicals, would find it cheaper to pay him many times their wholesale cost than to go farther and buy larger quantities. What I pay him, even when it is not payment for the skilled labor of compounding, is largely a payment of the same nature, as, were he not there, I might have had to pay it to a messenger."—*Exchange.*

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The Treatment of Chloro-Anæmia by Means of Hot-Air Baths.—Sulphur in Chlorosis.—Two Cases of Rotatory Dislocation of the Patella.—Reflex Glottis Spasm Following Distension of Stomach.—A New Treatment of Oophoro-Salpingitis.—Hydrotherapy in Childhood.—The Early Use of the Nursery Chair.—Treatment of Filaria.—Early High Amputation in Senile Gangrene.—Adiposis Dolorosa.—Separation of the Upper Epiphyses of the Femur During Scarlet Fever. 57

MEDICAL ITEMS. 65

Original Articles.

THE GEOGRAPHICAL DISTRIBUTION OF CHOLERA EPIDEMICS.*

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The earliest reliable descriptions of epidemic cholera were given by Sonnert in 1768-69, when it was prevalent at Pondicherry, India, and along the whole Coromandel Coast. It caused 60,000 deaths in one year. It visited Madras and Calcutta in 1781-82-83; and Hurdwar, when 20,000 pilgrims died in 8 days. It was present in Argot in 1787; Bellary in 1788; Travancore in 1792; and various parts of Bengal in 1811.

FIRST PANDEMIC.

The first pandemic, 1817-23, overspread the whole peninsula of India and included almost the whole habitable globe, its victims numbering millions. In four months it overspread Lower Bengal and by November had spread as far as Riva. It remained quiescent in December and February, but reappeared in March, 1818, in the same territory and extended thence over the whole of Hindostan, the greater part of the Deccan and along the Eastern and Western sea-boards of India, continuing to occupy additional Indian territories in 1819-20-21.

In 1818 it left its indigenous home and invaded Ceylon; and in 1819 it oc-

*Read before the Clinical Society of Maryland, November 4th, 1892.

cupied the whole Island. In this year it visited Burmah, Siam and the most southern point of farther India; Java, Bornea and the Sunda Islands. From Ceylon in 1819 it spread to Mauritius and Reunion and thence in 1820 to the sea-coast of Africa, but was limited to the Zanzibar coast. In 1820 it reached the Moluccas and Philipines and invaded for the first time the Chinese Empire, where it continued two years, spreading to Japan in 1822.

From Bombay in India it passed westward in 1821 to the east coast of Arabia; then along the coast as far as the confines of Mesopotamia; crossed to the coast of Persia, thence northwesterly along the coast to the Euphrates and toward the northeast into the interior of Persia. In the same year, by the Persian army, from Bagdad it was carried into the northwestern parts of Persia. Again arrested by the cold throughout this Asiatic territory, it reappeared in the spring of 1822 and spread along the Tigris to Mossul and Kurdistan and westward to Syria. During the winter of 1822-3 it appeared to die out; but in the spring of 1823 it started afresh and followed the coast of Syria as far south as Palestine, and in another direction to Damascus; and passed from Persia into Russia, entering Transcaucasia and traveling as far as Tiflis. In August it appeared in Baku, and thence by ship reached Astrakhan in September. Cold again arrested it, and it did not recur in the following spring.

"Thus ended the first act of the cholera drama on extra-Indian soil. Within the period from 1817 to 1823 the disease had spread over a territory of nearly one hundred degrees of longitude—from Nagasaki, in 147° E., to the coast of Syria, in 52° E.—and upwards of sixty-seven degrees of latitude—from Bourbon, in 21° S., to Astrakhan, in 46° 21′ N.—and in its western course it had come close to the frontiers of Europe, but without crossing them. The winter of 1823-24 had brought with it the complete extinction of the plague throughout the whole territory of central Asia that had been affected by it. For a space of four years the disease was again confined within the country of its origin, to begin on the expiry of that period a new career toward the borders of Europe and of northern Africa, and thereafter with rapid flight to make the circuit of the globe."—(*Hirsch.*)

SECOND PANDEMIC.

The second pandemic of cholera began in 1826, spread rapidly in Bengal, moved along the Ganges, through the Northwest Provinces and started westward. It continued in parts of India during 1826-27-28-29, and died out in the winter of 1830. In 1831 it advanced to St. Petersburg and Finland.

While thus advancing into the heart of Europe, it was in 1831 pursuing its old route by way of Mesopotamia and Arabia to Egypt; and in several years overran the north coast of Africa. During 1830-31 it occupied a large part of Russia; whence it passed into Germany by three routes.

1st, From Kalisch, in June, it crossed the Prussian frontier, moving westward. 2nd, It was brought to Danzig by Russian ships. 3rd, The route was from Russia into Austria.

In January, 1831, it crossed the frontier of Gallicia into Podolia, spreading over the whole of that country; entering Hungary in June, it advanced into Lower Austria, thence into Moravia and Upper Austria. From Silesia it then entered Bohemia. A few weeks after entering Galicia it appeared in Moldavia, proceeding thence to Wallachia, Bulgaria and Roumelia. In 1831 it reached Constantinople from Galatz by sea, and was carried thence to Smyrna.

From Germany it entered Great Britain in October, 1831, at Sunderland, from Hamburg. It spread quickly to Newcastle and Gateshead, by December had entered Scotland, and by March had secured lodgment in Edinburg and Glasgow. From Glasgow, in March, it was carried to Belfast and to Dublin, and, in April, to Cork.

In one year it had spread along the commercial highway over the greater part of Britain, along the coast routes and rivers, while the mountain regions were for the most part exempt, the Scottish Highlands absolutely.

It appeared in France about the same time as in England, reaching Calais and Paris in March, 1832, simultaneously, and spread over the greater part of Northern France before the end of May. By the middle of June it reached the southern department; of the 86 departments of France, 36 escaped. In 1833 slight outbreaks occurred.

From France it passed into Belgium, the Netherlands and Norway in 1832; but did not prevail to any extent until 1834. In the same year it invaded Sweden, following the river Gotha, the low inland planes and the lakes.

It reached the Western Hemisphere first in 1832, being brought to Canada by Irish emigrants. It spread rapidly along the St. Lawrence and its tributaries; the shores of lakes Ontario and Champlain; and appeared in the United States at Detroit, Michigan. It reached New York about the same time, being carried there by emigrants, thence it followed the coast to Philadelphia, reaching that city in July. In August it appeared in Baltimore, and in Virginia; and by October had invaded Kentucky. From Kentucky it followed the Ohio to Illinois and Indiana. In October it reached New Orleans and spread rapidly along the Mississippi. During the winter it died out; but it reappeared in the summer of 1833 with increased violence, spreading rapidly over the Southern, Middle and Western States. It invaded the Indian Territory, and crossed the Rocky Mountains to the Pacific.

In 1833 the Eastern States were exempt; but in 1834 it reappeared and spread to Nova Scotia. It reached Mexico and Cuba in 1833. New Orleans and Charleston were again subject to it in 1835, receiving the infection from Cuba. It invaded South America this year, and Central America in 1837.

While it was overrunning the Western Hemisphere, it was also extending into hitherto unvisited portions of Southern Europe. In January, 1833, it reached Portugal by ship. About the same time it appeared in Spain at Vigo, and soon traveled to the Mediterranean. In 1834 it prevailed more extensively, taking in the eastern district, which escaped in 1833. In 1834 it was brought to

Marseilles, whence it spread to Citta. Subsiding in winter, it broke out fresh in 1825, and overran the greater part of Southern France. The same year it reached Piedmont, and proceeded along the Ligurian coast to Tuscany, and northeast to the upper basin of the Po. In the same autumn it reached Venetian territory, and proceeding along the coast through Palestrina to Adria, coming in November to Padua, Vicenza, and Verona, and ultimately into Milanese territory.

Here winter arrested it, but in 1836 it broke out again in all the previously infected districts, and spread throughout Italy in 1837. In the same year it appeared in Malta for the first time. It also occurred in Switzerland, entered Austria from Venetia, and spread widely over Germany and Austria.

In 1837 it also spread through Illyria, and extended into Syria, appeared in the Archduchy of Austria, and extended eastward into Hungary. In August it entered Bavaria from the Tyrol. From Gallicia it passed into Poland, and into Western Prussia, and into Silesia. In all these places it showed little disposition to spread, and was arrested by winter.

From India it moved into China in 1830, into Japan into 1831, and into Africa and Egypt; and into Algeria in 1834-35-37. In 1837 it also prevailed on the east coast of Africa, in Abyssinia, and from Somali Land to Zanzibar and the Soudan. The winter of 1837-8 saw the close of the second pandemic; and for ten succeeding years Europe, Africa and America were entirely free from cholera.

THIRD PANDEMIC.

This began in 1846 and continued to 1863. In 1840-41 cholera was epidemic in India, but it was not until 1846 it became widespread in other parts of Asia.

In October, 1847, it appeared at Constantinople; but it did not become epidemic until the spring of 1848, when it spread over Turkey, the Danubian Principalities, Hungary, Asia Minor, Syria and Egypt, continuing in all these parts during 1849-50. It also entered Southern Europe in 1848 about the same time.

In 1847 it entered European Russia; but it did not spread extensively until 1848, when it extended over the whole empire, including Poland. Again arrested by winter, it did not reappear for two years.

It invaded Germany in 1848 from Russia, soon became widespread, and prevailed throughout the winter in several localities. In 1849 it overran Rhenish Prussia, continuing in 1850. The South and South-west of Germany escaped almost entirely.

In 1848 it appeared in England and Scotland again from Hamburg, and spread throughout Great Britain. In places it continued throughout the winter, but became more severe in the following spring, ceasing in the autumn.

In 1848-9 it prevailed in the Netherlands and in Belgium; and in 1848-50 in Denmark, Norway and Sweden to a slight extent. In Austria and France it began in 1849 and prevailed to the close of 1850. In Northern Italy it appeared

in 1849. Excepting the Iberian peninsula, cholera had now spread over the whole of Europe.

It reached North America in December, 1848, by New York and by New Orleans, being brought by emigrant ships. The same month it spread along the Mississippi to Memphis and by sea to Texas. In the course of this year, 1849, it overran all the States east of the Rocky Mountains. In April, 1849, it also entered Canada. It continued through 1850, and overspread the Western States. It also reached San Francisco from Panama in 1850. It continued in North America during 1850-51, but became widely prevalent in 1854 through a new importation from Europe. It prevailed in Mexico in 1849-50. It reached Panama in 1849 from New Orleans, but did not spread to any other Central American State.

In South America it appeared only in New Granada and Ecuador. It raged violently in the West Indies from 1850 to 1854.

In the Eastern Hemisphere a remarkable recurrence of cholera set in at the close of 1850, especially in the south and west of Europe and in Africa. In the northern and eastern parts of Algiers and Morocco a mild epidemic prevailed. In 1852 it broke out afresh in Persia, Mesopotamia and Poland.

In Russia it continued until 1862, and for the same time in Germany, visiting the same territory as in previous epidemics. In Finland, Sweden, Norway, and Denmark, it occurred epidemically in 1853. In France, it began in Havre, and later in Paris in 1853; but it did not prevail extensively. It entered Spain the same year at Vigo, and at Barcelona in 1854 from Marseilles; and in 1855 occupied the whole country. In 1857-58 it prevailed to a slight extent, but in 1859-60 it once more spread over the greater part of the country.

In 1853 it extended from Russia into Transylvania and the Danubian Principalities; and from France by ships of war into Turkey; spreading in the ensuing year over the entire Turkish territory, Asia Minor and Greece.

On the continent of Asia it prevailed extensively; also in India in 1852-58-60 61; in Java, Banda and Sumatra in 1852; over a large part of the East Indies in 1853-58; in Japan in 1854-57-59; and during the same period in Corea and China, where it continued until 1860; in Persia in 1853-56-57-59-61; in Afghanistan, Khiva, Turkestan, Mesopotamia and Syria in 1861, appearing in a virulent form; in Arabia in 1854-55-58-59 and in 1862; in Africa in 1853-55-58.

In North America it prevailed over the greater part of the continent in 1854. Scattered epidemics had occurred in Canada and the United States in 1853 and again in 1855; in Mexico in 1854; in Central America in 1856; and in South America in 1854-55-58-62-63.

The third pandemic therefore extended over a period of 15 years, "during which it had spread over the whole Northern Hemisphere, and to 25° south in the Old World, and to 30° south in the New.

Regarded as a whole, this pandemic shows numerous fluctuations of in-

tensity, the maximum falling in the years 1849-50 and 1853-55. In none of the intervening years was the disease altogether extinguished on extra-Indian soil, and there is no reason for attributing the fresh outbreak of 1853 in Europe, Africa and America, to a new importation of the morbid poison from its native habitat. All the facts tell rather in favor of a continuous reproduction of the poison in extra-Indian countries, and that power of reproduction was exhausted only after the lapse of more than ten years."

FOURTH PANDEMIC.

The fourth pandemic of cholera likewise extended over a period of more than ten years. Beginning in 1863 it continued until 1875. It was distinguished by its westerly course and the rapidity with which it extended to Europe, reaching it by sea from the coast of Arabia in a few days. It started in the lower basin of the Ganges in 1863. In that year and the two following, it visited "the whole Presidency of Bengal, the North-West Provinces, the Presidency of Bombay, the central and southern parts of the Deccan and Ceylon."

Disastrous epidemics likewise occurred in the East Indies in 1863-64; in China, and in Japan in 1864-65. In 1865 it reached the south coast of Arabia, southern part of the west coast of Arabia, and the east coast of Africa from Bombay. In May it broke out in Mecca, and the panic-stricken pilgrims scattered in all directions. It was carried to Suez, in May, by pilgrims on shipboard. Thus lower Egypt became infected early in June, thence by ships to "Malta, Marseilles, Constantinople, Ancona, Valencia and other places." It was carried in like manner to Asia Minor and Central Asia by pilgrims returning to their homes overland.

From Northern Africa and Southern Europe in 1865-66-67 the whole of both continents was overrun, and it extended even to the western Hemispher. In many places in France it continued through the winter of 1865 and became epidemic in the spring of 1866; prevailing most extensively in the north, but the south and the western sea-board did not escape. It reappeared in 1867 in mild form, subsided in the autumn, and reappeared in France no more until 1873.

It entered Italy in 1865, and continued through the winter and into the following year until March, when it subsided, to break out afresh with disastrous violence in August, causing 130,000 deaths. No province was spared, and even the island of Sardinia was visited. It abated in November, and during the winter of 1866 entirely disappeared from Italy.

In Spain it began in Valencia, whither it was brought from Alexandria via Marseilles; it spread rapidly over the whole of Spain, but subsided during the same year, to return no more except in a few isolated localities the following year.

Turkey formed the point of departure for the invasion of the east and north of Europe by this pandemic. It was brought by vessel from Alexandria to Constantinople in 1865. It extended rapidly through the greater part of the Ottoman Empire, along the west coast to the Black Sea, to the Danube, and along

this river through Bulgaria, and along the southern shore of the Black Sea to Trebizond, whence it took a southerly and westerly course into Armenia, and a north-westerly course into Caucasia. In 1866 it was confined almost entirely to the Danubian provinces; the following year it was limited to the northern part of Albania, and for the four succeeding years Turkey was free from cholera.

From Turkey, cholera invaded Roumania, August, 1865, and extended through Moldavia and the eastern part of Wallachia. During this year it prevailed in these sections to but slight extent, but in 1866 it prevailed violently in the southern part of Wallachia, causing the death of more than 26,000 persons. During the same time it prevailed in Montenegro, and again in 1867 when it passed into Herzegovina and Albania.

The disease entered Russia from Turkey at two points: by Caucasia, as we have already seen, and at its north-western extremity from Constantinople by way of Galatz and Odessa into Podolia, in August, 1865. It survived the winter in Southern Russia, to which it was limited; and in the summer of 1866 it "overran the central, western and southern governments as well." Throughout the empire the number of fatal cases amounted to 90,000, of which 18,000 belonged to Poland alone.

In 1867 it again prevailed in Russia, having once more survived the winter; but only in Poland did it attain great severity, where 11,265 more persons were its victims. By the end of this year it died out in Russia; reappearing the following year in only one locality, Lipowitz, in the government of Kiev.

In other States of Europe there was but little cholera in 1865; but in 1866 it spread over the entire Austrian Empire, including Hungary, causing upwards of 120,000 deaths. In 1867 it recurred in a more limited area; and was then arrested by winter, to return no more for four years. In Germany, it prevailed widely in Saxony in 1865; in Westphalia and the Rhine country in 1866, with more severity until the beginning of 1868. In North Germany it began in Pomerania in May; and spread rapidly over the eastern and western portion of the empire. In the kingdom of Prussia 114,683 persons succumbed to it. In the year 1868 it entirely disappeared from Germany. It also broke out in Great Britain in 1865, in Essex and Southampton, where it was brought by vessel from Alexandria. In the following year it was brought to Liverpool from Rotterdam and from these points it spread over the three kingdoms in 1866. A few sporadic cases occurred in 1867. In Belgium it began in 1865 and attained its full development by March, 1886, and then died out. It also occurred in the Netherlands in 1866, and spread rapidly over the whole kingdom, causing 20,000 deaths. It returned in 1867 with less violence. A few cases occurred in Denmark, Norway, Sweden and Finland in 1866-68. It invaded Switzerland in 1867, but was extinct by October.

It reached the Western Hemisphere in 1865, appearing first at Gaudaloupe, where it was brought by a French ship; sporadic cases soon after appeared in Martinique and in Dominica. In 1866 it appeared in San Domingo, and 1867 in Cuba, and in 1868 at St. Thomas.

Medical and Chirurgical LIBRARY Faculty of Maryland

The mainland of North America escaped in 1865, with the exception of one or two cases among the emigrants on Ward's Island. In 1866, however, it became firmly established in Nova Scotia, New York and New Orleans. To Nova Scotia it was carried by a vessel from Liverpool, bound for New York, which was compelled to put in at Halifax, because of an outbreak of cholera among passengers and crew. A small outbreak occurred also in Canada West. Twelve days later, it appeared in New York, on the arrival of the same vessel, though no close connection could be traced between the passengers or crew and the persons now attacked. In July it appeared at Governor's Island and in Brooklyn, and a little later in Philadelphia and Baltimore.

No considerable number of cases occurred anywhere but in New York City, where the deaths reached 1,210 between July and November. It extended from New Orleans over a great extent of country; along the Mississippi basin into Illinois and Iowa. The greatest mortality was in New Orleans, Memphis, Nashville and St. Louis. On the Southern coast, it prevailed in Texas, along the Rio Grande, and in Mobile. It occurred also in Savannah. It reached its height in August; afterwards declined; and then reappeared in the following year, mostly in the Western States.

It was seen no more in North America until 1872. It extended from New Orleans to Central America in 1866 and lingered there until 1868. It appeared first in the Paraguayan army, and extended then to the opposing forces of Brazil and the Argentine Republic. From the camp it was carried to Corrientes and vicinity. It the following year it burst out afresh among the troops, and also at Corrientes, and spread as far as Buenos Ayres. It subsided during the winter, only to break out again in the summers of 1867 and 1868 over the whole territory previously invaded by it. In the early winter of 1868 it again subsided, but it recurred once more at the close of 1868 in the Argentine Republic, and extended along the lines of trade to Bolivia and Peru as far as the sea-coast. It reached Brazil in 1867, and spread over a considerable extent of territory. It prevailed in Brazil again in 1868. Since that time South America has been exempt from this disease.

While cholera was thus extending westward from Arabia, it was also moving northward over the whole of nearer Asia, and to the southwest over the whole of Northern Africa. It entered Persia in 1865 and kept recurring during the six succeeding years. In another direction it followed the Tigris and Euphrates through Mesopotamia to Bagdad. In 1866-67 it was again prevalent in Mesopotamia. In 1869-69 it occurred in only isolated cases, but in 1870 it once more became widespread along the Tigris and Euphrates.

Syria became infected from Alexandria in 1865 at Beyrout and at Jaffa, whence it spread rapidly, but continued only during part of the following year (1866).

On the African Continent it first appeared at Somali and extended into the interior. In 1868 it appeared in Zanzibar, where it prevailed with great violence and rapidly spread along the coast, both north and south. In the summer of 1865

lower, middle and upper Egypt, and Nubia were overrun by it. Abyssinia was also invaded in 1865. It reached Algiers in 1865 from France, and Tunis, it is supposed, from Sicily in 1867. In Algiers this mortality is estimated at 80,000 in 1867 alone—for the two previous years no statement is given. In this year it terminated both in Tunis and Algiers. During the years 1869-70 cholera prevailed only to a slight extent at one or two points out of India, resting, as it had done in the third pandemic, for two years.

Russian soil remained a centre of infection throughout, but the disease was nowhere widespread. In the summer of 1869 it became more general and at most of the affected places "survived the winter and increased in the following summer, 1870, to an epidemic that spread over thirty-seven governments." (*Hirsch*). In 1871 it developed to the worst epidemic Russia has ever had, with a mortality of 130,000. It was most severe in the heart of the country. It again survived the winter in many places and in 1872 was but little less severe than the previous year, the mortality being estimated at 120,000; this year the southern and western portions of the country were chiefly affected. In most sections it died out with the advent of winter; but in Poland it continued and in the spring raged with increased severity, causing the death of 30,000 persons; it abated in the winter but became again active in the spring and continued to the end of the year (1874). In 1872 it spread from Poland to Austria, commencing in Galicia and extending west and north to Bohemia and Silesia, and south to Hungary.

It lasted in all this territory throughout the winter and assumed increased severity in 1873, spreading southward to Dalmatia on the Adriatic. In Hungary alone it is thought to have carried off 190,000 victims in 1872-73. By the end of 1873 it had disappeared from Austro-Hungarian territory. It reached Germany from Russia in July, 1871; did not become widespread except in East Prussia, and died out in November. In 1872 it reappeared in isolated points only, but in 1873 it became widespread, and by the end of July, had overrun all Germany, "the total ascertained number of deaths from cholera amounting to 33,156." Only in Bavaria and Silesia did it survive the winter, and in the spring of 1874 developed into an epidemic of great severity, which lasted until October. Therewith ended the fourth pandemic in Germany and in Europe.

From Russia it moved in 1871 in another direction into the Danubian Principalities and to Turkey, where it prevailed mildly during 1872-3. During this period (1871-3) it prevailed to but slight extent in Western Europe, being most severe in France.

In North America it reappeared in November, 1871, brought by a German emigrant ship which put in at Halifax. Here it made but little progress nor did it appear in the United States during this year. Not until 1873, and then from a fresh importation into New Orleans, did it once more spread along the Mississippi and its tributaries and over a great part of the interior plain of North America,

while the Atlantic Coast States escaped almost entirely. Just as the epidemic in Russia stood related to this general outbreak in Europe and North America, so was Persia the centre of a pestilential progress which traveled through nearer Asia and Egypt in 1871-2, extending on the one hand along the east coast of Arabia, and on the other along the Euphrates and Tigris as far north as Mosul. It appeared no more in Arabia until 1881, nor in Egypt until 1883. An isolated and unexplained outbreak occurred in Syria in 1875; it was widespread and lasted throughout the year.

"Apart from the isolated epidemics of cholera in Russia and upper Silesia in 1874, and in Syria in 1875, the disease became extinct as a pandemic in 1873. From 1875 to the end of 1880 it had shown itself at no point of the globe out of India. In India itself it has become a far-reaching epidemic several times within the last decade, particularly in 1869-70, 1872-3 and more recently in 1875." (*Hirsch.*)

In the countries visited by cholera, however certain sections have enjoyed a notable immunity; "as, for example, Switzerland, several mountain districts in the south-east of France, the south-east of Germany, especially Baden and Wurtemburg, the northern districts of Scotland and large parts of Greece; and there are examples of the same immunity, on a small scale, in numerous localities which have been repeatedly encircled by severe epidemics of cholera, and yet have remained free from the diseaae, notwithstanding that communication with the infected districts was not only not interrupted, but was even more frequent than before, because fugitives from the infected regions, both healthy and sick, were constantly resorting to these uninfected districts." (*Hirsch.*)

FIFTH PANDEMIC.

The fifth pandemic of cholera began in 1883 with an epidemic in Egypt. Concerning the appearance of cholera in Egypt in this year, the report of Dr. Chaumery, of Alexandria, goes far toward the establishment of the fact that it was not of local origin, as had been asserted by Dutrieux Bey, but had been introduced from India by the free intercourse of firemen and stokers of Red Sea steamers with the people of Egypt, and had reached Damietta on the Mediterranean by way of Lake Menzaleh. He shows also that merchants from India were present at the Damietta fair in June; also that, in consequence of diminution in the number of deaths in Bombay, the city council of Alaxandria had in June removed the restrictions imposed on vessels coming from Bombay, and that the Damietta outbreak followed soon after the removal of these restrictions (*Lancet*, January 12th, 1884.)

This fifth pandemic was of limited extent and brief duration. No invasion of North America occurred.

I present to you the above facts in regard to the course of this important disease in past epidemics. Lack of time has rendered it impossible to go further into the subject.

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BALTIMORE, NOVEMBER 12, 1892.

Editorial.

THE FIRST PAN-AMERICAN MEDICAL CONGRESS.

We have received the handsome Preliminary Announcement of this Congress, which will meet in Washington, D. C., on September 5th, 6th, 7th and 8th, 1893. Its President is Dr. William Pepper, of Philadelphia. Its membership is open to "members of the medical profession of the Western Hemisphere, including the West Indies and Hawaii who shall comply with the special regulations touching registration." The special regulations appear to be the payment of a fee of $10, which will entitle the member also to a set of the Transactions.

The President of the United States was authorized by Congress last July to invite the several governments of the Western Hemisphere to send official delegates. A very imposing array of names of medical participants is given under the "sections" from foreign American countries and from our own States. Maryland is fully represented by a dozen or more of her physicians from city and counties.

Contributors of papers are without exception required to place abstracts, not exceeding six hundred words each, of their papers in the hands of the Secretary-General, Charles A. L. Reed, M. D., of Cincinnati, Ohio, not later than July 10, 1893. These abstracts will be translated into English, French, Spanish and Portuguese; and will be published, in advance of the meeting, for the convenience of the Congress. Papers, or their abstracts, must not consume more than twenty minutes each in reading.

The Secretary-General writes us that the heavy expense of organization (about $5,000) must be met out of advance registration fees. He requests us to stir up the profession a little on this point; and sends us the name of the treasurer, Dr. A. M. Owen, Evansville, Indiana.

The Congress bids fair to be on an enormous scale, and its papers and discussions will be well worth attention.

OUR WEEKLY CHRONICLE.

The event of the week in medical circles has doubless been the visit of physicians to the Sheppard Asylum. Invitations were sent by the authorities of this suburban "Hospital for Mental Diseases" to some hundreds of practitioners of Baltimore, inviting them to come out by a special train on the Baltimore and Lehigh (Maryland Central) railroad and inspect the institution. In response, three carloads of medical guests visited the asylum.

They were received with a few words of welcome by a representative of the trustees; then shown over the buildings; then treated to an abundant feast; and finally addressed by the courteous Superintendent, Dr. Edward N. Brush, who pointed out the improvements made in the buildings and grounds during the year, and urged his audience to bear in mind that the asylum was ever ready to receive new patients. At present there are some thirty patients in the institution. The purpose of the foundation is to afford hospital care, and at the same time the attractions, of home life to white pay-patients. As far as we know only pay-patients are received. We gave last year in this JOURNAL a general sketch of the asylum and its founder.

The visiting physicians expressed themselves as very much pleased, both with the institution and with the reception tendered by its authorities. We have received the promise of some notes from its wards for publication in an early number of this JOURNAL.

The first general autumn meeting of the Clinical Society of Maryland was held this week in the State Faculty Hall. The subject, "Cholera," and the anouncement that five prominent teachers of medicine from our schools would speak upon its various aspects, drew together an audience which filled the large hall. Dr. W. E. Moseley occupied the chair. Dr. Chew was unavoidably calledout of town, Dr. Osler was detained by temporary sickness, but Drs. Thos. Latimer, I. E. Atkinson and Wm. Welch kept the audience in deepest attention until 11 P. M.; and then Dr. McShane, the City Health Commissioner, read a very interesting short paper on the existing preventive sanitation of Baltimore. We hope in this and succeeding issues to present a full stenographic report of the whole meeting to our readers.

We learn from Dr. Jackson Piper, of Towson, Md., that he has moved into Baltimore for the winter and will reside at 1121 N. Charles St., going out on occasion to Towson. He will be happy to see old friends at his new home.

The American Public Health Association will meet in the city of Mexico on the 29th of November, and sit four days. Excursion rate tickets good for thirty days will be on sale at all offices. A special train for physicians will pass through Austin on the morning of the 22nd, stopping over one day at San-Antonio. If a sufficient number of physicians wish to go and will make up their party, a special Pullman car can be secured for the through trip by writing to Major Lewis, the agent, at Driskill hotel, Austin.—*Texas Sanitarian.*

Medical Progress.

THE TREATMENT OF CHLORO-ANÆMIA BY MEANS OF HOT-AIR BATHS.

Traugott (*Wiener medicin. Presse*, No. 33, p. 1332) reports the successful treatment of fifteen cases of chloro-anæmia by means of hot-air baths. In all, a rapid and considerable increase in the percentage of hæmoglobin, as well as in the specific gravity of the blood and in the number of red corpuscles was observed; the irritability of the heart, the anæmic murmurs, the febrile attacks, and the neuralgic pains grew less; the appetite returned; the bodily weight increased; menstruation was resumed; and all of the symptoms gradually subsided. In spite of the profuse perspiration, and although the quantity of fluids taken was not increased, diuresis was augmented. In one of the cases the good effect of the treatment appeared to be enhanced by an extraction of blood. In individual cases from nineteen to forty-two baths were required. The length of the stay in the hospital varied from thirty-three to eighty-four days. The baths were given by surrounding the bed of the patient with barrel-hoops, over which was suspended oil-cloth, while the patient was well wrapped except about the head. At the foot of the bed was placed a wooden box lined with zinc, in which several spirit-lamps were made to burn. The temperature of the first bath may be as high as 131°, of the subsequent baths from 140° to 152°. In the course of the bath an ice-bag is to be applied to the head.—*Med. News.*

SULPHUR IN CHLOROSIS.

Professor Schulz, in the *Berliner Klin. Woch.*, again draws attention to the value of sulphur in certain cases of anæmia. After alluding to the prominent part played by sulphur in the life of the cell—a part analogous to that of hæmoglobin in the blood—and to the excellent results obtained by the use of sulphur waters in malarial cachexia, he comes to these conclusions:

1. In cases of pure chlorosis in which iron proves inefficient, the general condition is decidedly improved by sulphur.

2. After the administration of sulphur has gone on for some time, treatment with iron can be commenced and continued with success.

3. In cases of chlorosis complicated with catarrhal and inflammatory conditions of the digestive tract, sulphur is not borne.

Professor Schulz relates a case illustrating the advantage of the sulphur treatment. The patient, a woman thirty-four years of age, showed an extreme degree of anæmia, and had loud cardiac bruits. She complained of headache, giddiness, shortness of breath, palpitation, and complete loss of appetite, with pain in the epigastrium after food. Rest in bed with plain fluid diet was ordered, and this—with bismuth and morphine, and occasional doses of Carlsbad salts—relieved the gastric pain. Iron was tried, in the form of saccharated carbonate, but vomiting immediately set in, and its use had to be discontinued. Other preparations of iron were tried with no better result. Sulphur was accordingly given, and this she bore very well. Great improvement ensued: the anæmic appearance lessened, and the headache and palpitation disappeared. She was discharged from the hospital greatly bettered; but she still complained of some palpitation on considerable exertion. Iron was again given as the saccharated carbonate, and this time was tolerated without difficulty. The sulphur was used in the form of flowers of sulphur mixed with sugar of milk, as much being taken three times a day as would lie on the point of a knife.—*Med. Brief.*

TWO CASES OF ROTATORY DISLOCATION OF THE PATELLA.

(Under the care of Mr. William Anderson, St. Thomas's Hospital, London.) With regard to these cases Mr. Anderson has pointed out that they derive im-

portance from their comparative rarity and from the extreme difficulty sometimes experienced in their reduction. In the published observations by Streubel about one-sixth of the patella dislocations were rotatory, and of these about two-thirds were turned with the articular surface outwards, as in the examples now recorded. The mechanism of the displacement is by no means clear. Sometimes the accident is attributed to a blow, at other times to an attempt to recover from a false step, at other times to a fall, but there can be little doubt that in all it is a sudden and irregular contraction of the quadriceps that is the main factor. In Case 1 the patient felt the bone twist out of place while he was trying to regain his balance after a slip, and he was confident that he did not strike the knee; while in Case 2, on the contrary, there was a clear history of a blow on the outer side of the knee while the patient was rising from a kneeling posture. It has been found impossible to produce a rotatory dislocation artificially on the dead subject except by dividing the ligamentous structures and actually twisting the bone into its abnormal position by means of a lever introduced behind it, and from this we may assume that in any case mechanical violence applied on the living subject can only act by provoking the muscular spasm, which really effects and maintains the displacement. On theoretical grounds it would be difficult to imagine the extraordinary resistance offered by the luxated bone to the strongest efforts at replacement. Not the slightest impression could be made upon it in either of the following cases by very powerful leverage, although the patient was in a condition of surgical anæsthesia, with an apparently complete relaxation of the voluntary muscular system in general. In one case, quoted by Koenig, the bone is said to have defied reduction after the section of the ligamentum patellæ, and in another even after division of this and the tendon of the rectus also (Wolf). Gaulke succeeded by the use of a carpenter's vice, and others have achieved the end by introducing a lever or a hook beneath the bone, through an opening on the capsule. It is probable, however, that the great element of success is to push the anæsthetic until it vanquishes the resistance of the quadriceps extensor, the tension of which persists long after the other muscles have become relaxed; and as adjuncts to this the movement of flexion with rotation appears to be more efficacious than simple extension, and possibly because it draws upon the margins of the twisted bone through the intermediation of the stretched tibio-patellar bands. In the second case no lateral band could be detected, and here neither flexion nor rotation of the leg produced any effect. Should all manipulations, aided by full anæsthesia, fail to reduce the bone, the methods referred to above would be justifiable if carried out with due precautions; but it may be borne in mind that, although some deformity and limitation of flexion would remain where reduction is not effected, a very useful command of the joint may be regained.—*Lancet*, October 1st, 1892.

REFLEX GLOTTIS SPASM FOLLOWING DISTENSION OF STOMACH.

In the *Lancet*, October, 1st, the following case is reported from India: A soldier was admitted to the hospital with symptoms of laryngeal spasm. He had just eaten some chunks of goat meat.

This meat was uncooked. He then drank a large quantity of water. After his meal he sang for about an hour, at the end of which time he noticed occasional pain in his larynx, and cough. This was gradually succeeded by dyspnœa, which finally prevented his sleeping, and at 1 A. M. he was taken to a hospital.

On examination, beyond distension of the abdomen, nothing was visible. As far as could be determined the obstruction to breathing was in his larynx. His speech was whispering and quite altered in quality. He also complained of some

pain over the hepatic area. Hot fomentations were applied to his larynx, and occasionally inhalations of chloroform were given, but their effect was transitory. No emetic could be administered as the spasm prevented him swallowing. At 2 A. M., counter-irritation was attempted, and blisters were applied along the course of the vagi, and cupping over his stomach repeatedly performed. The result was well marked in about half an hour, the spasm stopping for a time and then recommencing. Finally an emetic was given, and about a pound and a half of meat vomited. From this time his symptoms improved still more, though for three days he had a spasmodic laryngeal cough. Hepatitis came on the day after his meal, but was easily cured. No laryngeal examination could be made, as there was no instrument for the purpose at hand. It is important to note that when once the laryngeal symptoms began to abate, the patient could swallow freely, so that direct pressure on the larynx by a mass of meat in the œsophagus was out of the question; while the marked effect of counter-irritation of the vagus seemed to point to the symptoms being due entirely to reflex irritation from the stomach. On August 23rd all his symptoms had ceased.

A NEW TREATMENT OF OOPHORO-SALPINGITIS.

Every practitioner is aware of the unsatisfactory means at our disposal (short of abdominal section) for the treatment of the above condition. At the best, in most cases, the patient is relieved of the acute symptoms, leaving the disease in a chronic stage for a weary length of time. Dr. Auvard, of Paris, announces the successful treatment of two cases by means of intermittent pressure, which he applies in the following manner: A Gariel's air pessary is introduced into the vagina and a bag filled with shot is simultaneously maintained over the site of the abdominal induration. The weight of the shot is gradually increased from 750 to 1500 grammes and the bag is kept applied for from two to three hours every morning and evening. During the interval (the pessary being also removed) hot vaginal injections and a cold enema are administered. In one case quoted, where a very tender swelling the size of a hen's egg could be felt in the right broad ligament, the tumefaction had completely disappeared after ten days of this treatment, and in three weeks the woman was well. In another case of oophoro-salpingitis induced by intra-uterine exploration, internal and external intermittent pressure, by means of a Gariel pessary and a shot-bag weighing one kilogramme, practised once daily for an hour and a half, relieved all the suffering and greatly reduced the swelling.—Paris Correspondence of *Lancet*.

HYDROTHERAPY IN CHILDHOOD.

Dr. J. Matas (*La Cronica Medica*) presents the following aphorisms on this subject:

1. It is certain that in the past the employment of cold baths for children was recomended more frequently than at the present time.

2. The cold bath may be regarded as a gymnastic measure, inasmuch as it strengthens the body and favors transpiration and secretion, and when carefully employed it is capable of preventing many diseases.

3. Hydrotherapy is preferred by children to many other hygienic measures.

4. It hardens them against exposure to cold, and thus becomes a prophylactic measure against a large number of diseases.

5. In healthy persons cold baths are not attended with ill effects.

6. Hydrotherapy is a powerful tonic procedure, and an energetic alterative in chronic diseases of children.

7. It is an excellent preventive of catarrhs, rheumatism, and all diseases resulting from exposure to cold.

8. The best hydriatic measures are general sponge baths and the various forms of the douche, of which the former are preferable in spring and the latter at other times of the year. In cases of very susceptible children, tepid baths should be first used, these being gradually reduced to 13° or 14°.

9. Children of any age may be thus treated, and the more general use of hydrotherapy will certainly reduce the mortality.

10. Hydriatic procedures must be of short duration, not exceeding a period of one minute.

11. Friction, massage, hydrotherapy, sun-baths and gymnastics represent the best means of invigorating a weak or lymphatic constitution.

12. The judicious employment of baths in childhood is a necessary adjunct in any properly directed system of education.—*Med. Brief.*

THE EARLY USE OF THE NURSERY CHAIR.

In reading the many valuable hints given as a solution of the various nursery problems that perplex inexperienced mothers, I have often noticed directions for making various protectors for the mother's dress in the shape of lap-pads, etc., and the fact has become more and more apparent to me that many mothers do not appreciate the value of using the nursery chair from earliest infancy or the simplicity of the formation of the habit.

Indeed, in the case of very young infants, it is only necessary to begin at the beginning. Instruct the nurse to hold the child over some convenient receptacle after every meal and every nap, however short. The habit will be formed before you have regained your health, and it is only necessary to keep on for the few following weeks to fix the habit beyond all danger of relapse. It is surprising how soon a call for the chair may be interpreted by the accustomed ear.

In teaching older children already confirmed in bad ways considerable patience is needed, but the gain in cleanliness and comfort is so great that any sacrifice is well-paid. Obviously, it would be subject to variation depending on the age of the child, its conditions of health, etc.; but I have yet to learn of the failure of the plan, where it has been perseveringly tried.

The results of this habit, once learned, are so plainly in the direction of the comfort and the health of the child and mother that they scarcely need enumeration. The bungling masses of cloth, tightly pinned about the baby's limbs, which are said to be one of the most potent causes of bowed legs, may be dispensed with, and only sufficient covering provided for warmth. The rubber abominations which are frequently resorted to, to prevent the child from complete drenching, may be abandoned. Emphatically one of the best things to be said of the result is the riddance of one of the worst elements in Baby's care, *i. e.*, the washing of the diapers. In my own experience I have found the use of three, weekly, to be amply sufficient; one for day wear, one for use at night, and one to use in case either of the others became too badly soiled from contact with the floor. Obviously, when the baby begins to creep, the number used would depend upon the child's individual proneness to soil its clothes in general, —Clippings from an article by Mrs. Hood in *The Mother's Nursery Guide.*

TREATMENT OF FILARIA.

Dr. Manson, of London, gives a very thoughtful paper on this subject in the *Lancet,* October 1st. He says in part:

My experience of the action of thymol on the filariæ of the blood coincides with that of Surgeon-Lieutenant-Colonel A. Crombie, as in the *Lancet* of August 13th. Soon after Surgeon-Lieutenant-Colonel E. Lawrie's article on this subject ap-

peared in the *Lancet*, of February 14th, 1891, I had an opportunity of trying thymol in the case of a negro in whose blood both species of African filariæ—viz., filaria sanguinis hominis diurna (major) and filaria sanguinis hominis perstans (minor)—abounded. This patient took thymol regularly for over two months without any effect whatever on his blood parasites—at all events at the time—and six months later they were quite as abundant and just as active as before treatment commenced. The attempt to cure filarial chyluria by the administration of a parasiticide, as suggested by Surgeon-Lieutenant-Colonel Lawrie, is founded on a misconception of the true pathology of this disease and of the part played by the filaria in its production. The filaria stands to chyluria very much in the same relationship as rheumatic fever stands to heart disease and gonorrhœa to urethral stricture; it starts the disease process, but its constant presence is not necessary for keeping it up. To attempt, therefore, to cure chyluria by trying to kill the filaria is as illogical and as useless a proceeding as to attempt to cure established heart disease by salicylates, or stricture of the urethra by astringent injections. This is evident if we consider the order of events in the production of chyluria.

The embryo filariæ, although they are generally present in the blood and urine in chyluria, have nothing whatever to do with its production. This is further proved by the fact that in some few cases of genuine and persistent tropical chyluria no embryo filariæ can be found either in blood or urine. I had recently such a case under observation. In such cases the parent filaria must have died after injuring the thoracic duct, or possibly there may have only been a male or an unimpregnated female parasite present. Furthur, although the parent filaria was necessary for the production of the lesion in the thoracic duct in the first instance, its continued presence there is not necessary for the maintenance of the lesion. So that whether the filaria which originally wrought the mischief dies or lives is a matter of no consequence as affecting the chyluria; the stricture of the duct once produced is permanent, and the chyle will continue to flow along the compensatory anastomosis, and perhaps from time to time burst the walls of the varix and appear in the urine. That this is the pathology of most cases of chyluria is proved by more than one post-mortem examination, as well as by a multitude of observations on the living subject. This being the case, it is difficult to see in what way benefit could accrue from killing either the emrbyo or the parent filaria, or how an anthelmintic, even supposing it were effective as such, could possibly cure chyluria. Many declare they have cured chyluria by drugs; but those who say so should bear in mind that nearly every case of chyluria ceases spontaneously from time to time and also recurs spontaneously, no matter what treatment is adopted. I have no doubt Surgeon-Lieutenant-Colonel Lawrie's cases recovered while taking thymol, but I do not think they recovered permanently, or in consequence of taking this drug; and so with Dr. Walsh's cases referred to by Surgeon-Lieutenant-Colonel Crombie. A knowledge of the pathology of chyluria, elephantiasis and filaria disease in general teaches us that our endeavors ought to be directed rather to keeping the parasite alive and in a healthy state than to interfering with it and worrying it into conditions of ill-health in which the functions of gestation are imperfectly performed. There is a considerable body of evidence to show that under normal conditions the filaria is innocuous, and that it is only when abnormally located, or when it acts as an irritant, or when from same cause the contents of the uterus are prematurely evacuated, or when it dies, that this parasite becomes a danger to its human host.

I hold that, once established in the human body, the filaria should be left alone, protected rather than persecuted. Pathology indicates that the proper treatment of chyluria is in principle the same as the treatment of acquired varix in any inaccessible region. This should be rest, elevation, lowering of the tension in the lymphatic vessels by the use of saline purgatives, limited and appropriate food, abstinence from fluids as much as possible. Certain drugs have been vaunted as specifics for chyluria; I have tried several of them, but never with success of a permanent character. Temporary recovery from time to time is the rule in chyluria, and the drug which is in use at the time when the urine clears spontaneously, from healing of the rupture in the varix of the bladder, is often credited with the cure. I cannot understand how the drug given by the mouth can possibly cause the closure of a gaping varix in the bladder.

EARLY HIGH AMPUTATION IN SENILE GANGRENE.

Writing in favor of early high amputation in this complaint, and reporting one new case of his own, Dr. Powers, of New York, says:

Proposition to resort to early amputation through thigh in cases of senile gangrene due to arterio-sclerosis was first seriously made by Jonathan Hutchinson, who presented, in 1883, an exceedingly clear and forcible argument before the Medico-Chirurgical Society of London, calling attention to the fact that amputation in obstructive gangrene due to arterio-sclerosis has been largely discountenanced because followed by sloughing of the stump, and urging that this only takes place when the part is removed too near to the disease.

When amputation is done at a low point the condition of the vessels will rarely be found to be such as to admit of repair; gangrene of the stump usually occurs immediately and places the patient's life in much more danger than before operation.

By the "high amputation" which he urges in these cases, he means that in the case of gangrene of the foot the amputation should be made above the knee, and in that of the hand, at or near the shoulder-joint.

In gangrene due to arterial calcification the interference with the blood-supply is usually greatest in the distal part of the arterial system, and is of such nature as to be steadily on the increase. Hence the hopelessness of improvement and and the great danger of advance. Hutchinson adduces a number of cases in which he successfully amputated through the lower third of the thigh for gangrene of the foot, and avers that the procedure is not attended with much danger, even in advanced years and with most extensive calcareous degeneration of the arteries. He has never seen secondary hæmorrhage in such cases, nor has he encountered difficulty in securing the vessels at the time of the operation.

After criticizing a list of some 27 cases by Küster and others he says: The list shows that through the high amputation all patients were saved who were not severely afflicted with some general disease.

Careful study of the cases of Hutchinson and Küster, together with the observation of others in which disaster has followed low amputation, serves to convince me of the wisdom of the course indicated, and in so far as we may be guided by present knowledge, I think that we may accept as authentic this statement of Heidenhain's:

"So long as the gangrene be confined to one or two toes, one may wait and abstain from other than general antiseptic treatment, with high position of the limb, allowing the part to be spontaneously thrown off. If the process extends, however, to the dorsum or sole of the foot, one should amputate above the condyles of the femur.

"Amputation below the knee is almost always followed by gangrene of the flaps, and brings the patient in danger. High amputation is indicated, then, when the gangrene progresses, even though the patient be without fever."

ADIPOSIS DOLOROSA.

In the *American Journal Medical Sciences*, November, 1892, Dr. Dercum, of Philadelphia, gives a very interesting illustrated article on this newly described condition. We quote a brief description of one of the cases reported by him: The patient first noticed the malady fifteen years before in her forty-ninth year.

Five years ago her attention was called to a peculiar condition of the right hand. The last phalanx of the second finger began to be fixed in a flexed position, while the end of the finger appeared to be growing somewhat smaller. Later the remaining fingers of this hand became involved and all the phalanges deformed. The deformity as seen now is flexion of first phalanx, marked over-extension of second, and half-flexion of the third. The thumb is also stiff, but all of its joints are flexed. For some time she has noticed the thumb of the left hand becoming like that of the right.

A year ago the patient had a quasi-rheumatic attack affecting the deformed hand and arm. The pains seemed to run up and down in the arm rather than the joints.

Some months ago had pneumonia of the right lung, and made a good recovery.

For several months past had slight uterine hæmorrhage at times, associated with which were dull, aching pains, resembling those formerly felt before menstruation.

She said that the enlargement had spread from the knees to the thighs and buttocks unequally, that the left thigh and buttock had been earlier aud more conspicuously enlarged than the corresponding parts on the right side. Gradually, however, the latter became enlarged to an almost equal degree. Later, swelling appeared over the left arm, and later still on the back and sides of the trunk, and wherever appearing it gradually became diffused and finally reached very great proportions. The patient further volunteered the statement that she had formerly been very slight in build.

To ordinary observation she merely presented the appearance of an excessively obese person. However, examination soon revealed that the enlarged tissue was very unevenly distributed. In the region of the knees, where it had first made its appearance, it was excessively irregular and lumpy. It gave a nodular and elastic feel, and could not be made to pit on pressure. At the same time of the examination no tenderness existed in any of the lumps, but shooting pains were referred to them in various situations. This was particularly the case in the mass over the right hypochondrium. In addition, she complained of scalding sensations on the inside of the right cheek and the right side of the tongue. Nothing abnormal could be discovered in the mucous membrane of these parts. No tenderness existed in any of the nerve-trunks at the time of the examination. The patient was excessively weak, and could move about her bed or sit up only with great difficulty. Her grip was almost *nil*. No tendon jerks could be elicited—probably due to purely mechanical difficulties. For the same reason, an electrical examination could not be made.

Dr. Henry found that there was slight analgesia, and diminished temperature and tactile sense, and further, that the "changes of sensory acuteness were not more marked over the distribution of any of the cutaneous nerves, but seemed dependent entirely upon the amount of the subcutaneous tissue."

Dr. Henry, it appears, found no area of absolute anæsthesia anywhere. However, a year later, such an area undoubtedly existed on the back of the left arm, and extended thence over the posterior aspect of the left shoulder. On the opposite side, anæsthesia was not present, although no marked difference, if any, existed in the amount of the subcutaneous tissue. A marked increase in this subcutaneous tissue had, however, everywhere taken place during the past year. Comparing, for instance, the measurements of the arms made by Dr. Henry and myself, it was found that the left forearm had increased one and seven-eighths inches, and the right forearm one and three-eighths inches; the left arm one and a half, and the right arm two inches. This increase seemed to be maintained throughout.

Subjectively, the patient complained much of headache. Her face was very much flushed, and she suffered greatly from cardiac dyspnœa. It was a persistent and distressing symptom.

Examination of the eyes proved negative, as did also that of the urine. Perspiration, according to the patient's statement, was scant. Face not involved in the enlargement. No subnormal temperature. Hair thin, but not excessively so. No difficulty in speech. No mental impairment.

SEPARATION OF THE UPPER EPIPHYSES OF THE FEMUR DURING SCARLET FEVER.

January 15, 1891, E. C., male, four years; was ill in the spring of 1890 with scarlet fever; he had always been a healthy boy, active and perfectly formed. He had a long illness, and made a tedious recovery; he had several abscesses, one in front of the ear, one over the larynx and one below the great trochanter on the left side. These all seemed to be superficial. He became greatly emaciated, and digestion was very poor. He was carried out of doors each day, and in autumn had sufficiently improved to be able to walk, in so doing showing a very awkward mode of movement. It was described by his father as a waddling gait. His appearance and movement were characteristic of double congenital hip dislocation. On drawing the limbs down and shoving up again they move through a distance of about an inch and a half, and there was felt a cartilaginous grating in each limb, most marked in the left. No tenderness or swelling existed; his general health was excellent; he has no pain and sleeps well.

The diagnosis was undoubtedly separation and probably absorption of the epiphyses. I recommended fixation and extension by the use of a Thomas' double hip splint. This treatment was not adopted, and the boy was taken to an institution in the United States, where a complicated appliance was employed.

In January, 1892, I examined the boy again and found that mechanical appliances of various kinds had been employed with a view to correcting the lordosis and keeping the femora in place. There is, however, little or no improvement. When the weight rests upon the feet the trochanters are carried far above the normal line. In any case of this kind I think it exceedingly doubtful whether an ambulatory appliance can be devised which will retain the femora in right place in reference to the acetabula.—Dr. McKenzie, *University Medical Magazine.*

The New York State Association of Railway Surgeons will hold its second annual meeting in the Academy of Medicine, New York City, November 14th, 1892. The profession is cordially invited. Geo. Chaffee, President.

Medical Items.

We are pleased to report that Dr. H. Salzer, 1623 John St., after spending several weeks in traveling through the West for the benefit of his health, has returned, fully recovered.

A correspondent of the *Southern Practitioner* writes that "we sorely need a work on the practice of medicine for the Southern part of North America and for South America. Here is a chance for one of our subscribers.

Dr. J. E. Gichner, formerly Associate Editor of this JOURNAL, has just returned from a pleasant and profitable stay at the Old Sweet Springs, W. Va., where he has been practising during the season. He has resumed his practice as formerly, on Wilkens Ave.

Dr. Engel Reimers reports three cases tending to support the view that acute yellow atrophy of the liver is a result of the syphilitic poison. In these cases the first symptoms appeared about seven months after the primary sore. Therapeutic measures were without avail, but the reporter had the satisfaction of seeing his diagnosis confirmed at the autopsy in each instance.—*Med. Rec.*

We desire to announce to physicians who will attend the Southern Surgical and Gynæcological Association in Louisville, Ky., November 15, 16, and 17, that the Galt House will be headquarters for the members of the Association. Those who desire commutation rates must obtain from the ticket agent at the place of starting a certificate that they have paid full fare to Louisville, and upon this certificate a return ticket will be issued at one cent a mile. A number of new names of contributors have been added on the final programme.

The issue of the *Bulletin of Pharmacy* for October, 1892, from which we have this week clipped several items, contains a large amount of information in regard to incompatibilities in prescriptions which is so important to physicians (not being easily procured elsewhere) that we have written for a private copy of the said issue to place it among our text-books on therapeutics. Especially valuable is the article by Dr. Fink (continued from the September number) entitled "One Thousand Practical Hints for Dispensing Pharmacists."

Dr. David Cerna, late of Philadelphia, has received the appointment of Demonstrator of Physiology in the Medical Department of the University of Texas, and Dr. Geo. P. Hall, of Galveston, the appointment of Lecturer on Diseases of the Ear, Nose and Throat. Dr. Cerna has arrived at his post of duty, and judging from the high character of his credentials, the medical department has received quite an acquisition. Dr. Hall is already well known to the Texas profession as a physician eminently qualified in his specialty.—*Texas Sanitarian.*

The *Annals of Ophthalmology and Otology* has been removed from Kansas City to St. Louis, Mo., Dr. James P. Parker, Editor, P. O. Box 405, St. Louis, Mo. The *Annals* will be improved and will continue to maintain a high standard, as no other than a professional interest is fostered. The *Annals* is not a journal for specialists only, but a special quarterly journal for the general surgeon and physician who aspires to the highest attainable advancement. Subscriptions are now being received for 1892 and 1893 (volumes I and II). All the numbers of volume I (1892) will be furnished to new subscribers at half price, *i. e.*, those who remit $3.00 will receive the *Annals* for 1892 and 1893. The supply of back numbers is limited, therefore it is necessary to subscribe early in order to secure the 1892 volume complete.

Another troublesome form of incompatibility causes substances to act upon each other in such a manner as to reduce their mixture to a plastic mass or fluid consistence. Zinc sulphate and lead acetate, when rubbed together, yield a wet mass. Antipyrin and sodium salicylate, when mixed and dispensed in powder form, undergo decomposition, with the formation of an oily layer which saturates the paper. Antipyrin and beta-naphthol form a pasty liquid when rubbed together. Lead acetate and sodium salicylate form a plastic mass which subsequently grows hard. Quinine and salicylic acid, rubbed together, form a plastic mass and should not therefore be dispensed in powder form. Chloral hydrate is liquefied when brought in contact with camphor, monobromated camphor, menthol, lead acetate, sodium acetate, and carbolic acid. Chloral hydrate, thymol, phenol, beta-naphthol, resorcin, pyrogallic acid, menthol, and salol are liquefied in contact with camphor.—Dr. Fink, *Bulletin of Pharmacy.*

The following is from a "school-boy's composition on bones" in the *Weekly Medical Review.* We give it because the impressions left by physiological and anatomical lectures on a child's brain are very difficult to discover, and any light thrown upon them is interesting: "Bones are the framework of the body. If I had no bones in me I should not have so much shape as I have now. If I had no bones in me I should not have so much motion, and grandmother would be glad, but I like to have the motion. Bones give me motion to cling to. If I had no bones my brains, lungs, heart and large blood vessels would be lying around in me and might get hurted, but now the bones get hurted, but not much unless it is a hard hit. If my bones were burned I should be brittle, because it would take the animal out of me. If I was soaked in a acid I would be limber. Teacher showed us a bone that had been soaked. I could bend it easily. I would rather be soaked than burned. All my bones put together in their right places make a skeleton. Cripples and deformed people don't have no skeleton."

Mr. Stanford, in his address at the British Pharmaceutical Conference at Edinburgh, said of ptomaines: There appears little doubt now that infectious diseases are the product of the ptomaines resulting from the action of bacteria; these highly toxic alkaloids have been mistaken for other poisonous alkaloids in post-mortem examinations of human subjects where poisoning was suspected. In some criminal cases these have been mistaken for coniine, strychnine, delphinine, and morphine, which they closely resemble in their reactions. Others resemble nicotine, atropine, digitalin, veratrine, curarine. It is obvious, therefore, that the post-mortem examination for poisons presents hitherto unsuspected difficulties. Many fatal cases of poisoning have also occurred from the presence of these ptomaines in meat, especially pork—which bears out the value of the Mosaic restriction. The following toxic ptomaines have been isolated, and their formulas are known: Cadaverine, isoamylamine, neurine, choline, mytilotoxine, typhotoxine, tetanine and mydatoxine. No doubt many more will be added to the list; but Professor Simon points out that the bacterial proteids produced from the bacilli of cholera, typhoid fever and diphtheria are even more poisonous, and have not yet been isolated. Dr. Koch's "tuberculin" is also a poison of extraordinary virulence. When these bodies are known, the diseases may be conquered by fighting the bacteria with their own products, thus adopting a new and true homœopathic treatment. The pharmacist will be called upon to isolate and prepare these bodies, and I hope he will also have a large share in the great work of their further investigation.—*Ex.*

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Original Articles.

SOME DOCTORS OF YE OLDEN TIME.*

BY GEORGE W. ARCHER, M. D., EMMORTON, MD.

There is perhaps less known about our local doctors of the olden time than about any other intelligent class of men. Although in the old documents, newspapers and ledgers which I have seen of the colonial period, some fifteen or twenty are mentioned as residing in what is now Harford County, there is nowhere a scrap of information about their professional career, and indeed there is very little information about them of any kind, though we have indirect evidence that several of them were prominent, influential and worthy citizens. Strange to say, we have from these sources more information about the first of them all, "Dr. John Waterton, of the Gunpowder River," than about those of a much later period. Dr. Waterton represented our portion of Baltimore County in the lower house of the Provincial Assembly from 1671 to 1678. After he sunk the doctor in the politician, however, he was usually called "Captain." As no mention is made in his will of wife or child, he probably died a miserable old bachelor. His will, which was proved in 1684, bequeathed legacies to persons in Gunpowder Neck of the name of York—who were probably his relatives—and all his land in England and Maryland to his nephews in the mother country. The name of

*Read before the Historical Society of Harford County, October 22, 1892.

York seems to have become extinct hereabouts, but, through the female line, are descended Scotts, Bonds and Adys, still living among us, having probably a modicum of Dr. John Waterton's blood in their veins. In 1673 he bought a tract of land in the fork of the Gunpowder—an interesting transaction, from the fact that it is perhaps the only instance in the history of Baltimore County in which conveyance was made by the very old procedure called "by turf and twig" which seems to have consisted in handing over to the purchaser a handful of soil and a twig from the forest, as typical of the delivery of the land and of all that grew thereon.

Dr. Josias Middlemore, a well educated Englishman, came over in 1720 and bought land in Bush River Neck, where he settled and married—no doubt practising his profession, though there seems to be no positive proof of the fact. He was remarkable for his piety and for his numerous acts of benevolence. He died in 1775, aged seventy-three—surviving all his children, three in number. Next in order of time were Doctors Benjamin Crockett, Edward Wakeman and — Annen, who were prominent citizens.

During the sixth decade of the last century there were some half-dozen physicians in the county. Dr. Henry Stevenson and Dr. Alexander Stenhouse settled in Bush River Neck, where they married sisters. They were men of mark—the former probably had few superiors anywhere—but unfortunately, being Englishmen, they both took the wrong side in '76 and had to flee from the country until the struggle for freedom was over, when, on returning, they found their property confiscated. Dr. Stevenson meanwhile held the position of Surgeon in the British Army. He soon regained full favor, and died in Baltimore in 1814, at the advanced age of ninety-three, pursuing his profession almost to the last, and highly esteemed for his many virtues.

Dr. Hugh Bay practised at the present Churchville and was a brother of Rev. Andrew Bay, at that time pastor of the Presbyterian Church there. Dr. Ephraim Andrews, who was also a justice of the peace—as were many physicians in the last century—owned a large tract of land called Westwood on Graveyard Branch, which includes the site of one of the two oldest Presbyterian churches in Baltimore County. The exact circuit of the labors of Dr. — Ross and Dr. Gideon Van Cleiffe is unknown to me.

In 1765 Dr. James Spavold lived on Delph Creek, in Bush River Neck, where he kept a school for several years—but whether he practised medicine or not, there is nothing to show. A few years later Dr. Charles Sigismund Fietz was in practice between Winter's and Bynum's Runs. In 1769 and 1770 he inoculated for Mrs. Ann Bond, widow of Joshua Bond, three of her children and sixteen slaves. A few years before the Revolution Dr. John Dale was settled near Joppa, and Dr. Thaddeus Jewett probably near Bush, as he attended several families thereabouts.

Five physicians were active members of the local Revolutionary Committee in 1774, 1775, and 1776, namely, Drs, Robert Lemmon, Josias Carvill Hall, Moses

Haslett, Thos. Andrews and John Archer. Of these Dr. Hall afterwards commanded a regiment of the Old Maryland Line. Dr. Haslett died in Baltimore in 1796. Dr. Archer's career, professional and other, is pretty well known hereabout. Dr. Richard Sappington was a surgeon in the patriot army. The following are entered in Dr. John Archer's medical ledgers as having met him in consultation at various times soon after the Revolution—this meagre information is all I have as yet been able to learn concerning them: Doctors William Webb, James Lee, Philip Henderson, Philip (?) Lansdale, Nathaniel Blaney and John McComas.

Now, here are more than two dozen doctors, of whose professional life, with two or three exceptions, we know almost nothing—in most instances merely their names having come down to us—while, of some, even the names are in part forgotten. And doubtless there are others who are consigned to utter oblivion.

It is a matter of some interest therefore to know that there is extant a small note-book which was kept by a worthy doctor, not yet named, who practised his profession in this region, antedating all of them, with the single exception of Dr. Waterton. It was kindly lent to me by Miss Libbie Whitaker, daughter of the late Hon. Franklin Whitaker, having been written one hundred and seventy-seven years ago by her maternal ancestor, Dr. Buckler Partridge. To be sure, the information which it conveys is very meagre, but a synopsis of it is worth giving, in view of the deplorable dearth of knowledge concerning our doctors of the olden time. I think we may safely suppose Dr. Partridge to have been a pretty fair representative of the physicians of his day in the province—certainly not below the average.

I ought perhaps to have said before that though all the above-named practitioners of medicine were called doctors, it may have been only by courtesy, for it is pretty certain that some—perhaps the majority of them—never took a degree in any medical college. Prior to 1768 there was no such institution in America—that being the year in which John Archer, of this county, took the first medical degree ever conferred in the New World, his diploma received on that occasion being now in the library of the Medical and Chirurgical Faculty of Maryland—and very few indeed of the colonists could afford to spend in Europe the three or four years required to obtain a degree. It is, however, quite likely that Waterton, Middlemore, Stevenson and such others of them as came from the Old World after reaching manhood, had received diplomas there. Dr. Partridge may have been one of these. When or how the remainder acquired such professional knowledge as they may have possessed, will probably never be known—presumably, however, from medical books—though it must be confessed that in the early part of the last century such books were very few and very far between.

To prepare you for some of the startling remedies used by Dr. Partridge, I will say that in those early days—especially in this wilderness, as our region then was—very strange remedies were sometimes resorted to by physicians, and when a physician could not be had, which was often the case, still more extraordinary were the curative measures adopted by the patient's non-professional friends—

by no means the least being spells, charms and witchcraft. What better could be expected from the common people, when the very fountains of justice were tainted with such heresies, if the language used was to be depended on to impart and not to conceal ideas? I have now before me three original commissions from as many governors of the province, bearing dates, respectively, 1702, 1715, and 1720, appointing the Justices of Baltimore County and instructing them as to their duties. Their Honors are directed "to enquire by ye Oaths of Good and lawful men of ye County, of all and all manner of Fellonys, Witchcrafts, Enchantm'ts, Sorcerys, Magic Art, Trespasses, Forestallings, Engrossings and Extortions w'tsoever."

In cases of snake-bite, which, of course, were comparatively common then and too urgent to wait for incantations, the reptile, if it could be gotten, was cut into tiny bits, which were applied to the wound. The principle of this mode of treatment may still be seen occasionally in this community—in spite of local option—in the case of some old toper who has recourse to the hair of the dog that bit him, or, rather, the hair of the dog with which he bit himself. If the lone hunter was bitten by a venomous reptile, he boldly gashed the part with his hunting knife and thrust grains of gunpowder as far as possible into the bleeding incisions. This treatment, which must have left the patient very little chance of surviving, was possibly adopted because of the prevailing belief that the brimstone in the gunpowder would counteract—or perhaps placate—the devil who was almost universally supposed to lurk in the serpent. For rheumatism, the fat of wolves, groundhogs and skunks was well rubbed in. Erysipelas demanded the application of a black cat's blood, while in dysentery, the still more repulsive excrement of the same weird animal was administered internally. Indeed, within the last fifty years Dr. Joshua Wilson and Dr. Samuel Birckhead—both now deceased—had the greatest difficulty in preventing this horrible outrage upon a dysenteric patient by his officious "friends." In a case which occurred nearly one hundred years ago in the practice of Dr. John Archer, a man who had been badly injured by falling upon an inverted pitchfork, attempted, while awaiting the doctor's arrival, to get relief by means of a poultice applied, not to the wound, but to the offending pitchfork. It is some comfort, however, to know that the patient as well as the officious friends of the man with the dysentery, resided a little north of Mason's and Dixon's line.

Many queer notions also prevailed as to the mode of manipulating the indigenous remedies while in the act of gathering them. One was, that the bark of the walnut tree—a very common remedy in early colonial days—if gathered as a purgative must be stripped downward; if an emetic effect was desired the stripping process must be upward, in the direction of vomiting.

Possibly after these statements some of Dr. Partridge's remedies may not seem so very repulsive—or perhaps I should say not so very unreasonable—as otherwise they might well do. The doctor's recipes, about 150 in number, beginning with the first page of the little book, which is 8x4 inches, fill by far the greater por-

tion of its 66 pages. They were evidently collected and copied by him before leaving England; the last few pages only being devoted to a brief record of his pursuits, professional and other, during the first few months after his arrival in Maryland. Between the recipes and these records, however, is a "Mem.," which speaks for itself, and tells incidentally how and when the Doctor crossed the ocean:

"The 14th of September. In 1715.—Then delevared Mrs. Barraclift (about half an hower after eaight o'clock at night, of a female child) on board ye good Ship See Horse, Capt. Joseph Whealer, Comd'r., bound for Penselvenia."

Subsequent entries show that if he first landed in Pennsylvania he came on at once to Maryland.

I will now give a few of the most striking of the Doctor's numerous formulas, promising, for justice's sake, that many of them which I do not give are really very good and (*mutatis mutandis*) very much in accord with the practice of the present day. It must be borne in mind that, as before stated, he got them all in the mother country; it is reasonable to suppose that in selecting them he kept in view the difficulty of procuring here the remedies most used in England. For such, he has substituted, when possible, others which were to be found growing in the woods and fields of Maryland. Hence it is, perhaps, that there are scarcely any mineral medicines among his formulæ.

"Ale a Gainst Scrophula: Take chips of guaiacum, Sassaphrag, Walnut tree rind, Roots of Sharp pointed Dock, filipendula, hound's tongue, a ℥ ii; herb Robert arch angle, a M.(Maniples?)4; Rasins of ye Sun, stoned lb.1, live millipeds (this is no other than our old friend, the squirming thousand-leg) one pint. Prepare all for five galls. It is good against a cancer and cutaneous affection but Singularly and Specifically respects ye King's Evil." Surely the evil to be swallowed was worse than any King's evil. Earth worms make part of a recipe for the scurvy. A 19th century patient would probably agree with the Doctor that this was scurvy treatment. Others, however, might say he was only trying to worm himself into favor among strangers. The Doctor says "it knappeth off ye sharp points of ye salts and forceth ye acrid Ichor to evaporate either by insensible Effluvia or Sweat."

"Diuretic Pills: "Take powdered bees ℥ ii"—and so on—the other ingredients being salt prunel, salt of amber, mustard seed, oil of anise-seed and Venice turpentine. Each dose contains eighty grains of powdered bees. The Doctor adds, "They liquefy the compages (whatever that may mean) of ye blood, deterge ye glands and interiour recesses of ye body and stimulate ye veins, scour out mucus and sand and powerfully promote urine."

"Viper Powder: Take trochees of vipers (or rather viper's flesh dryed) gr. 15, salt of amber gr. 3, saffron gr. ii—make a powder. It is held a great arcanum against ye jaundice."

"Epidemial Powder: Take troches of viper ℥i, Virginia snake-root, contrayerva a ℥ss; mix." The dose is "from one to two scruples." A modern patient

would probably have a few additional scruples in swallowing it. The Doctor, however, says it will cure the ague, and as he practised along the water-courses, where that disease did most abound, we may be moderately certain that his belief had at least one good result—namely, the extermination of venomous snakes, though whether or not the patients were proportionately exterminated, is what "no fellow" is likely to find out at this late day.

"A Pleuritic Julep: "Take goat's blood"*—and so on. From this prescription we may know that "juleps" were in vogue hereabouts even at that early day—such as they were.

There are some half-dozen recipes for "Lohocks"—something to be licked. The advantages of several other prescriptions are enforced in the vigorous phrasiology characteristic of those days. For example, "A Decoction against ye Scurvy" is said to "attenuate, depurate and briskly actuate ye blood and juices, it desolves scorbutic concretions, unlocks appilations, turns off feculencies by diaphoresis and duresis." Another prescription "gives a check to ye raging orgasme of ye spirits, satisfies ye fervour of ye rarified boiling blood, melts down gellid lymph and promotes urine." "An Antiemetic Julep" "obtends ye acrious ferment, recals ye vigour and tone of ye stomach, regulates ye furies of ye spirits, charms ye spasme of ye fibrillæ and effectually stops vomiting." "A Corallate Mixture," "wonderfully and almost miraculously like a god in a machine, as they say, represseth subversions of ye stomach and motions to vomit, etc." "A Bitter Stomach Powder" "warms, roborates, deterges and useth to bring considerable advantage when by reason of daily hard drinking, sotting and soaking, the fibres of ye stomach being over-washt, become lapse like a tripe, and its villa being slobbered over with slimy putrilage, retain nothing—whence arise loathing of food, morning strainings and vomiting."

As many contend that every book ought to have a moral to justify it, I will venture to supply one for the professional part of this little volume, namely, that with earth-worms, bees, live millipeds and vipers for medicaments, patients had a lively time in getting them down, and before takiug a gulp it is more than likely that they discussed with sympathizing friends whether the disease was not preferable to the remedy. But what will a man not do for dear life? So, we may fancy them, in those old times, merely making old wry faces (no other kind of old rye was made at that day) and washing the defunct reptiles and other animals down with a draught of the Doctor's favorite "frog-spawn water." Think of it! oh ye impatient patients of these degenerate sugar-coated days, and thank your stars that when *your* swallows homeward fly they take down with them no such disgusting medleys.

The remaining few pages contain a record of some of the Doctor's dealings with the settlers about the head of Gunpowder river during the first few months after his arrival, presumably before he had got fully into practice. From these

*I must confess I have a suspicion that goat's blood, as here meant, was the product of an herb: but I cannot find it in any work, botanical or medical, to which I have access.

it is evident that when about leaving his native land, he did not have entire confidence that his professional practice would be, at the outset, ample for his support; hence he supplemented it (beforehand, as it were) by laying in a trader's outfit, on a moderate scale, to give him a start. For example:

"Mem. of Goods sent to Mr. Mears to Gunpowder." These (which are given in detail) are, "9 guns"—each being described—"200 gun-flints, 7 bullet-moulds, 1 of brass and 6 of iron"—beneath which is written: "One buck and 2 Doe Skins Rec'd. for 1 Gun." There is no date, but it is evident that these articles had been sent on in advance, most probably from England.

"February ye 22nd, 171⅝, Mr. Wm. Tibbs, his account:

	c.	qt.	lbs.	
To a bed rug, 2 blancets and pills,	3	0	0	(Tobacco.)
To medicine	8	3	12	
To 16 black brod cloth @ 72 lbs. (tobacco),	11	2	2"	

The purchaser of the above was Rev. Wm. Tibbs, rector of St. Paul's parish from 1702 to 1732, who occasionally officiated at the church near Joppa, of which, a few years later (in 1721), he became rector. If we may judge from the quantity of medicine and broad-cloth purchased, it would seem that his Reverence bought on speculation, probably to eke out his salary.

"Mr. Edward Cocks, Dr., to Buckler Partridge, ye 27th of Feb'y., 171⅝, viz.:

	c.	qts.	lbs.
To Long halfe stock Gunn	4	0	10

To 56 yds. of Cantaloune, for which I must have 100 lbs. tobacco, 2 buck skins, 2 doe skins and 2 pair of shoes."

The above shows that tobacco and peltries were about the only currency in the province at that time, peake and roanoke (strung shell-beads) having nearly gone out of circulation, and coins not having yet come in to any extent.

"March ye 19th, 171⅝.

Mr. John Husk, Dr., to Buckler Partridge, viz:

	c.	qt.	lbs.
For a Sute of Cloase,	6	0	0"

Another account shows that Edward Tally paid six buck-skins, at ten shillings per skin, for two guns.

The two following accounts seem to indicate that professional charges were then made on a principle widely different from the fee-bill of our own time. The first is against "Mr. Richard Taylor" for seven prescriptions, averaging about four shillings (nearly one dollar) each. No visits are entered. Then comes an account against "Madam Calegate," a highly respected and well-to-do lady of that day, for three prescriptions, averaging only four pence each. Also, "for my attendance and care, one shilling." I am inclined to think that in the former case the charges for prescriptions included visits; while in the latter instance there were no visits, the word "attendance and care" not necessarily implying that there were.

I have been able to learn but very little more about Dr. Partridge. In 1732 he and Jane Partridge, whom I take to be his wife, witnessed the will of a man who lived west of the Big Falls of Gunpowder, in Back River Upper Hundred, which they proved six years later. In 1738 the Doctor wrote the will of a man who left him, as his friend and creditor, all his property, including a plantation. In the following year, 1739, he was witness to a third will, and this is the latest information that I have of him. "Daubney Buckler Partridge" is mentioned in Aquila Hall's assessment book of 1762-3, as "Jane Partridge's son." The indications are, that the family had removed west of the Gunpowder. Willam and Joseph Partridge, probably of the same family, are alse named in one of Mr. Hall's books, of 1762; and it is not at all unlikely that the family of Partridges once prominent in Cecil County were descended from one of them.

Although the name has become extinct in this county abundance of the blood has descended through the female line. Two of Dr. Partridge's daughters married two sons of Thomas Bond, an English Quaker, who with two or three brothers came to Maryland about the year 1700, and settled in the Harford portion of Baltimore County. Thomas Bond owned a large body of land on Winter's and Bynum's runs at the time of his death, which took place on his estate at Emmorton, in January, 1756, in the seventy-seventh year of his age. His remains lie buried near the door of his home, in an unmarked grave, beneath an old pear-tree, the exact spot of his burial being unknown. Though uneducated, we have ample proof that he was highly esteemed and had much influence for good in the community where he lived for more than half a century. Hundreds of his descendants are now living, many of them in this county, and in Baltimore city and county; and as many more in several other States of the Union. About one half, perhaps, of all these descended from the two above-mentioned daughters of Dr. Partridge who married sons of Thomas Bond. Among their descendants are many of the Bonds, Wilsons, Whitakers, Prestons, and Hollands, who now reside in this county.

A CLINICAL DESCRIPTION OF DYSENTERY AS IT OCCURS IN NICARAGUA.*

BY JUDSON DALAND, M. D.

Three varieties of dysentery are met with in Nicaragua, namely, the malarial, the endemic, and the epidemic, and of these the malarial is by far the most common. The prodromal symptoms of malarial dysentery are malaise, pain in the back, in the head, and in the umbilical region extending toward the pubes. In association with the diarrhœa these pains are highly characteristic of this form of dysentery. Mild cases are marked by very slight febrile and circulatory disturbances; whereas in the more severe cases, we have a moderate elevation of temperature, varying between 102° and 104°F. The stools are at first composed almost entirely of pure mucus, are small in quantity, and are frequently attended

*Read before the Philadelphia County Medical Society, October 26, 1892.

by tenesmus; soon the mucus is streaked with blood. The pains are not usually severe during the act of defecation, but the pain in the head and back is excruciating. Liver complications are not infrequent, particularly acute hepatitis or acute hepatic engorgement, each of which is frequently associated with jaundice. Hepatic abscess is a rare complication and is usually secondary to the ulceration of the colon. At times the spleen becomes greatly engorged.

Changes in the urine, indicative of kidney disease, probably exist, but chemical and microscopical examinations are rarely made from lack of proper instruments and reagents. Many of these cases of malarial dysentery are followed by intense anæmia and debility, lasting for several months.

When cases are seen early and promptly treated, the prognosis is almost uniformly favorable, but when seen late they usually die. As post-mortem examinations are never permitted, no information exists regarding the morbid anatomy or pathology of this interesting disease. The amœba coli, if searched for, would be found in many of these cases.

The treatment found most successful by Dr. Bermudez, of Managua, Nicaragua, is as follows: To an adult is given six grains of quinine morning and evening, in conjunction with—

℞.—Ammonium chloride . . . . . gr. v.
Pulv. ipecac . . . . . gr. v.
Tr. opii . . . . . gtt. x-xv.

To be repeated every two hours.

The amount of laudanum is determined by the severity of the pain. When the pain is particularly severe and obstinate, morphine is superadded, and, in cases marked by debility, it is customary to substitute the carbonate for the chloride of ammonium in five-grain doses, every two hours, day and night.

In the way of food nothing is permitted except milk, or milk and lime-water, to which sago may be added. The patient is allowed to drink freely of cool water, thus alleviating the intense thirst which is usually present. Ice-water is considered harmful.

The *second* variety, known as endemic dysentery, resembles the preceding, but is very much milder, and is usually unattended by the fever or the severe pains in the head, back, extremities, or abdomen that characterize the malarial form. The stools are composed of feces mixed with mucus and blood; are less frequent, and the tormina and tenesmus are less severe.

The average duration of malarial dysentery is three weeks, but occasionally it has been known to last two months, while very mild cases run their course in two weeks.

The treatment for this variety is the same as for the malarial, with the exception that the quinine is omitted. Almost all cases recover, and complications or sequelæ are uncommon.

The *third* variety recognized is called epidemic dysentery, which, as a rule, comes on suddenly, with pains in the head, back, throat, and extremities, ac-

companied with severe abdominal pains, shooting in character and centering at or about the umbilicus. Headache is particularly complained of; and not infrequently nausea and the vomiting of bile are associated. From the first the discharges are bloody, frequent, and there is intense pain and tenesmus. There may be as many as one hundred and fifty evacuations in the twenty-four hours, and an ordinary case may average twenty-four in the twenty-four hours, or one hourly, day and night. The temperature is high, ranging from 104° to 106° F., with a morning remission of two degrees, at which time there may be moderate perspiration. Severe cases die in less than seven days, and favorable cases may recover in from two to three weeks.

The discharges from the intestines continue bloody throughout the disease, but change in color, becoming dark and sometimes black from decomposed blood-pigment, and frequently they are viscid and tenacious from admixture with mucus.

At times the patient becomes delirious, and occasionally coma supervenes. Children often develop twitching of the muscles, rolling of the eyes, and there is a tendency to bury the head in the pillow.

The complications usually noted are hepatitis, jaundice, and abscess of the liver. Usually so soon as hepatic complications occur the patient dies; in other cases epidemic dysentery is complicated by croupous pneumonia with rusty sputum, and it usually affects the base of the right lung. Now and then severe internal hæmorrhages occur, and such an accident explains the cause of sudden death which has been occasionally observed. In this form of dysentery the anæmia and debility are more marked than in the malarial form, and is more persistent. Not infrequently the patient suffers from obstinate constipation, due to stricture resulting from the healing of large and deep ulcers in the colon.

These cases are best treated by the administration of from ten to twenty grains of quinine given three times daily, and in addition chloride of ammonium, five grains; pulverized ipecac, five grains; and tincture of opium, ten to fifteen drops, repeated every two hours. Frequently, however, there is so much gastric irritability that these remedies are not retained, and in such cases the quinine is continued, but the chloride of ammonium and ipecac mixture is omitted, and fifteen grains of bismuth or five grains of tannic acid repeated every two hours, is substituted. When opium is indicated it is invariably administered in the form of the tincture, in doses of five to fifteen drops, repeated every two or three hours according to the severity of the case. At times nitrate of silver, in doses of one-sixth or one-eighth of a grain in pill form, is given every three hours. If the astringents mentioned prove of no avail, recourse is had to the acetate of lead, in doses of two or three grains every three hours. Most cases require stimulants, and experience has shown that alcohol in the form of brandy or whiskey is *inadvisable*, and that the best results are secured from the use of sherry, port, or any of the red or white wines, associated with the carbonate of ammonium, in ten-grain doses repeated every three hours.

The food is restricted to milk and lime-water, sago, and farina. Not infrequently Dr. Bermudez has seen as many as one hundred cases in two months with the mortality of but 2 per cent., and his father would probably see as many as two hundred cases in the same length of time.

Dysentery is one of the most common diseases of Nicaragua, and typical examples of the disease may be seen any day in the year. Most cases of malarial dysentery are observed during December, January, and February, while the epidemic variety occurs more frequently during the months of March, April, May. Of course, endemic dysentery is always present, and, as would be naturally expected, is equally prevalent at all seasons. The malarial form prevails chiefly in low, marshy districts, during the hot months. It is well to remember that the dry season, which corresponds to our summer, begins in November and ends in April, the remaining months constituting the Nicaraguan winter, or wet season. The average maximum temperature in the dry season is from 95 to 98 degrees. There is a difference of at least ten degrees between the temperature of the day and that of the evening.

The contagiousness of epidemic dysentery is fully recognized, and all ordinary precautions are taken to prevent the spread of the disease. Isolation, the free use of carbolic acid, the burial of all discharges, especially fecal and urinary; the burning of the linen soiled by the discharges; and in cases where the patient is too poor to submit to the destruction of clothing by burning, they are disinfected by boiling water.

In all of these cases no researches have been made regarding the presence of the amœba coli.

Nicaragua has excited much interest of late, particularly in view of the probability that in the near future the Nicaraguan canal will become a reality, which will bring it into intimate relations with the entire world. I have, therefore, ventured to record these observations regarding a disease which prevails constantly, and at times becomes contagious.

My thanks are due to my friend and student, Dr. Salvador Bermudez, and to his father, who has practised in Nicaragua for more than thirty-five years, for the description of dysentery as it appears in Nicaragua, and for the treatment which has given them the best results. The enormous experience of the physicians of Nicaragua has heretofore never been made known to the medical profession, in so much as they have no medical magazine to which they could report their observations; and, moreover, at no time has it been their custom to carefully note the cases under their care; so that this report is of particular value, and is, perhaps, the first of the kind published in the English language. It is especially worthy of note, that the greatest confidence is placed in the use of the chloride of ammonium, and that this is their uniform practice. I would, therefore, suggest that it be employed in the United States, especially in the Southern States, where the climate more nearly resembles that of Nicaragua.

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BALTIMORE, NOVEMBER 19, 1892.

Editorial.

KEEP YOUR GERMS HEALTHY.

Every one has germs. In the great world of germs there are certain that he may claim as peculiarly his own. In fact, when we consider the matter in a philosophical light it might seem as if the human body existed simply in order to afford a breeding-place for germs. Every nook and cranny of the skin is full of germs. The whole intestinal canal swarms with them, in myriads that no man may count. The respiratory tract boasts its own peculiar breeds. And, speaking of breeding, a fellow-physician, who is learned in these matters, informs us that one germ (supposably a female) will have between sixteen and seventeen millions of germ-babies a day. Just think of it! How so many germs can feed upon one poor man and each have babies at this rate, it fatigues the editorial mind to consider.

In order to account for the fact that there is anything at all left of a man at the end of his first day we may suppose that he has friendly germs which get used to living on him and defend him from foreign germs belonging to other men or to the universe at large. We may infer under ordinary circumstances a man's germs are fully able to protect him. Only when a lot of small-pox or measles germs first invade him from some other man's body are his germs unable to protect him. At the first onset they are completely overcome by the invaders, but if he lives long enough his germs will either expel or assimilate the foreigners (just as the English absorbed the Northmen) and when assaulted again they usually have learned the enemy's methods and repel all attempts to secure a foothold.

But a man must be very careful to keep his own germs in good condition. If they get out of health they cease to act as faithful policeman and develop burglarious tendencies. They break into the great workshops and storehouses and swarm along the avenues in such dense throngs that the business of life is greatly impeded and sometimes comes to a full stop.

One peculiar thing about a sick or impoverished germ is that (like some poverty-stricken invalid women), it has the more babies the worse off it is. When a germ gets into really unhealthy surroundings it develops also venomous properties. A germ that is naturally as harmless as a garter-snake, may, if kept on bad rations, on an unwashed skin or unflushed mucous membrane, become more deadly than a copperhead. A lot of these unhealthy germs will kill a man before the doctor can find out what is the matter with him.

The moral of it all is, "take care of your germs and they will take care of you." Keep your germs healthy and contented. Let the body juices on which they feed be free from taint. See that the skin germs have a sweet clean home in which to reside and breed. Let the germs of the respiratory tract have pure fresh air about them lest they develop pneumonic or catarrhal tendencies. See to it that the mouth germs have no unwholesome surroundings, to worry them into diphtheritic phrensies; that the gastric germs have a healthful home, unpolluted by indigestible or decaying solids or liquids; above all, see that the cleansing bile corrects all possible typhoid or septic tendencies in the great germ-swarms of the intestines.

A germ is a patient, long-suffering creature, but even a germ (like the storied worm) will turn against too cruel ill-treatment.

Finally, do not, like the nations of old, attempt to kill off your germs by poisoning their source of nourishment. It will but injure you and rouse them to fury. Be wise, rather, and nurse them back to health, and they will be once more your best friends. Restore their normal surroundings and nourishment, and they will at once lose their unnatural ferocity and become as domestic as before.

OUR WEEKLY CHRONICLE.

The Board of Medical Examiners for the State is still active in its efforts to carry out its duties under the "New Law." We are requested by its President to notice in the JOURNAL the following announcement to the profession, which, as a personal letter, has, we understand, been mailed to all the physicians of Maryland:

"The Board of Medical Examiners wishes to call the attention of physicians throughout the State to the law passed by the General Assembly of Maryland at its last session, and to ask that they will give their valuable assistance in making known its provisions and in securing the enforcement of the same.

"The Board wishes especially to call attention to section 43 of the Act, which reads in part: That all persons commencing the practice of Medicine or Surgery in any of its branches, after the passage of this Act by General Assembly, shall make written application for license to the President of either Board of Medical Examiners which said applicant may elect; also to section 50, which reads: 'Any person to whom the provisions of this Act apply, practising or attempting to practise medicine or surgery in this State, without first having

obtained the license of one of said Boards of Medical Examiners, shall be guilty of a misdemeanor, and shall pay a fine of not less than fifty dollars, nor more than two hundred dollars, for each offence, or in default of payment shall be confined in the city or county jail until the fines and costs are paid, and shall be debarred from recovering compensation for services rendered as such physician or surgeon.'

"It is the earnest desire of the Board to have clearly understood the purpose for which it has been appointed, and to furnish promptly through its Secretary any information which may be desired as to the provisions of the law or the time at which examinations will be held.

"You are respectfully requested to send to the Secretary at your early convenience the name and address of any one to whom you have reason to believe the medical act applies, and who may not be aware of its more important features.—S. T. Earle, M. D., President; James Bordley, M. D.; W. F. Lockwood, M. D., Secretary; Executive Committee."

The Board is empowered by the law simply to examine persons who apply for examination and to license applicants who come up to the required standards. Persons believed to be practising in defiance of the law must be brought to the notice of the Secretary by individual physicians or by the medical societies, and, if there is evidence that they are violating the law, their cases will be referred to the proper prosecuting agents of the city or State. The Board does not prosecute. It simply examines and licenses, or, we suppose, acts as an agent in laying information against violators before the State officers.

We are pleased to learn that Dr. J. E. Michael, Professor of Obstetrics in the University of Maryland, performed, October 25th, 1892, the operation of symphysiotomy upon a parturient woman and delivered alive an infant with a biparietal diameter of 4 inches. The mother's pelvis measured in the oblique conjugate 3½ inches. The patient was able to walk well on the 12th day. We are informed that this is the first operation of its kind performed south of Mason and Dixon's line and the fourth in America.

Reviews, Books and Pamphlets.

Diseases of the Chest, Throat and Nasal Cavities, including Physical Diagnosis and Diseases of the Lungs, Heart and Aorta, Laryngology and Diseases of the Pharynx, Larynx, Nose, Thyroid Gland, and Œsophagus. By E. Fletcher Ingals, A. M., M. D., Professor of Laryngology and Practice of Medicine, Rush Medical College; etc., etc. Second edition, revised and enlarged. 240 Illustrations. Octavo, 700 pages, extra muslin, price, $5.00. William Wood & Company, New York.

Among the many works recently published on this subject, this one stands very high. Its treatment of the entire respiratory tract with very concise points as to the differential diagnosis of the many similar and allied troubles cannot fail to recommend the book as a text-book for the student and a very valuable help

to the busy practitioner. While it gives full attention to the modes and means of diagnosing, with the use of instruments of the latest invention, and to the thoughts on the subject up to date, the subject of treatment is somewhat neglected.

Professor Billroth's Surgical Clinic at the Vienna General Hospital; Size 24x32; Price $2. Wm. Wood & Co., Publishers, Nos. 45, 47 East 10th St., New York City.

We are in receipt of the above pictures, the most recent series of strictly technical pictures, very appropriate for decorating the walls of a physician's office and reception room.

These pictures are good copies of paintings and engravings, antique and modern, upon medical subjects, both humorous and pathetic. Their styles and prices recommend them to the physician who likes to adorn his office with suitable pictures.

Lea Brothers and Co., Publishers, Philadelphia, promise to issue shortly a Text-Book of Nervous and Mental Diseases, by LANDON CARTER GRAY, M. D., Professor of Diseases of the Mind and Nervous System in the New York Polyclinic. Octavo, about 800 pages, richly illustrated.

In the forthcoming text-book, American physicians are promised a clear statement of a department of medicine of peculiar importance to them. The task assumed by the author is one of exceptional difficulty. It would have been comparatively easy to gather abundant literature upon a subject of such enormous growth, but to weigh, select and condense, requires exceptional qualities of mind. In a word, Dr. Gray has undertaken to provide students and practitioners with a compact volume containing a working knowledge of neurology, space being principally devoted to the diagnosis and treatment of all diseases belonging to this department. The series of illustrations will be largely original and singularly rich. The work is assured of the highest position as an authority for the physician and as a text-book for the student.

Medical Progress.

SACRAL RESECTION.

We clip a few paragraphs from a paper by Dr. E. E. Montgomery, of Philadelphia, in the November number of the *American Journal of Obstetrics:*

The operation known as sacral resection was introduced in 1885 by Kraske for the treatment of some of the forms of malignant disease of the rectum which were not amenable to relief through the perineum and the rectal outlet. The operation consists in making a bow-shaped incision over the sacrum, beginning at the left sacro-iliac synchondrosis, carrying the incision across to the right and beyond the point of the coccyx. The incision is made down to the bone, and the muscle cut away from the sacrum and the ligaments from its left border. The coccyx is then enucleated, the rectum pushed off from the sacrum, and with chain saw or bone forceps the left side of the sacrum below the third sacral foramen is cut away. This may be done either laterally, as we have just suggested, or transversely. The latter procedure has been recommended by Bardenheuer and others. It has seemed, however, preferable to make the incision upon one side, for the reason that in so doing the nerves which make their exit from the fourth sacral foramen on the opposite side,

and supply to a limited degree the rectum and the bladder, are left undisturbed.

No fears need be felt regarding injury of the sacral canal, for the canal of the dura mater does not extend so low and the filum terminale has no special significance. The removal of a portion of the bone higher up, involving the third sacral foramen, will be attended with serious injury to the sacral plexus of nerves, as the third foramen gives vent to quite a voluminous distribution of the nerves.

In conclusion we would earnestly advocate the performance of sacral resection:

1. In all cases of malignant disease of the middle and lower third of the rectum.

2. In every case in which the establishment of an artificial anus is necessary and it is possible to bring down healthy gut to the lower border of the resected sacrum.

3. It affords a ready method of reaching the retro-uterine extraperitoneal tumors, as well as those situated within the peritoneal cavity behind the uterus.

4. The application of the operation to the removal of the uterus would be limited to those cases in which the vagina remains undilated and the uterus is more or less fixed, and even in such cases the choice may lie betwen sacral resection and abdominal incision.

5. It does not seem preferable in operation for disease of the Fallopian tubes, as they can be reached more readily through the abdominal incision.

TREATMENT OF UTERINE HÆMORRHAGE.

Writing upon this topic in the *Amer. Jour. Obstetrics*, November, Dr. Vander Veer, of Albany, says in reply to the question of what is the best treatment for such hæmorrhage:

Take the case of prolonged hæmorrhage in girlhood. The conditions are present such as we have referred to—a flexion of some sort; a stenosis with enlargement of the body of the uterus; the endometrium is covered with a fungoid growth; small polypi are present; there may be a true condition of endometritis fungosa; perhaps there may be present a distinct polypus. Have we any better line of treatment for these conditions than a thorough, careful dilatation of the cervical canal, complete and thorough curetting, and then with care packing the cavity of the uterus with sterilized gauze, dipped or not in a solution of some mercurial, or iodoform gauze, thereby maintaining complete and thorough drainage? This is a method of treatment I have followed out for the past five years, enlarging upon it more and more as the degree of safety seems to have become greater, occasionally allowing the patient to wear afterward, for relief of the flexion, an intrauterine stem pessary. I believe that in all cases where a simple uterine polypus has been removed a thorough curetting should be done and packing with gauze carried out.

Take the condition of hæmorrhage that follows parturition, and which keeps up for many months or years, as the result of subinvolution—chronic metritis. The patient has probably been given medicines unlimited, yet her recovery will not follow until some such line of treatment is pursued.

In the treatment of hæmorrhage due to uterine fibroid I am thoroughly anchored in the belief that for the small, persistent bleeding fibroid there is no better course to be pursued than the removal of the uterine appendages; although it is possible now and then, when the fibroid is simply submucous, that by careful curetting we may be able to enucleate it sufficiently, or that the uterus will

take on contractions and force it out, thereby saving our patient the more formidable operation. However, these cases must be handled with great care. Rigid antisepsis must be carried out and the after-treatment cautiously pursued or septic conditions will develop. In a medium-sized or large fibroid, where it becomes difficult to remove the uterine appendages and the hæmorrhage is gradually destroying the patient, there can be no better treatment, it seems to me, than hysterectomy in some form.

As to the class of cases in which hæmorrhage occurs at or after the menopause, if we cannot be certain that they are malignant, requiring either a vaginal or supravaginal hysterectomy, let us give the patients the benefit of the doubt, keeping them from the atmosphere of fear of malignancy just as long as possible; but in the persistent hæmorrhage that may come on from the non-malignant conditions that present after the change of life, let us by all means give them the benefit of thorough curetting and the treatment that I have endeavored to bring out in this paper.

I know that there have been many criticisms made upon the question of entering the cavity of the uterus in so formidable a manner, but I am certain, from the experience I have had in many cases, that it is a safe procedure, but must be done in the most thorough way as to cleanliness and drainage, and I believe there is no drainage superior to that of the gauze packing.

INTUBATION FOR FECAL IMPACTION.

In the *Cincinnati Lancet-Clinic,* November 12th, Dr. Schenck relates the following case:

Mrs. L. S., blonde, aged thirty years, first pregnancy. I was called to see her the evening of December 29th, 1891, and found her suffering from intense pain. She said pain began the afternoon of December 25th. Fearing it was going to be an abortion, upon the advice of friends her family called in a midwife, who left her some of Hoffman's anodyne and advised the injection of water per rectum. As this did not relieve the patient they sent for me.

I found that she was about four months' pregnant. There was considerable tenderness and some swelling in the left iliac region, in which situation she would have paroxysms of pain lasting about fifteen minutes, the interval between these pains varying from thirty minutes to two hours. She had not slept for several nights. She said she could feel a lump in the left iliac region, comparing it to a ball, and that when it descended the pain began. Her tongue was slightly furred, temperature 101°, pulse 120, not much tympanitis; she said she had a stool regularly every day. While I was there she had a pain, but I could not detect any contraction of the uterus. From the symptoms a diagnosis of fecal impaction of the sigmoid flexure was made, which treatment verified.

Treatment.—As the water injections did not reach the mass, and the compound licorice powder which she had taken failed to soften the same, and as there possibly was danger of an abortion resulting from irritation, prompt measures were indicated. She was placed in the genu-pectoral position and Langdon's colonic tube introduced. After about two and a half feet of the tube had entered the bowel the patient said that she felt something move away. Four feet of a five-foot tube was introduced, and two quarts of warmed olive oil slowly injected by means of a Davidson syringe. This was at 10 P. M. She had no pains until 3 A. M. the next morning, when she had a slight one. About 7 A. M. she had a copious evacuation in which were some small hardened lumps of feces.

I advised small doses of compound licorice powder when the stools lacked a mushy consistency. After this time there was no further bowel trouble. She went on to full time, and was delivered of a live nine-and-a-half-pound male child.

HÆMORRHOIDS.

In an article concerning "Reconstruction of the Pelvic Structures in Woman," Dr. H. Marcy, of Boston (*American Journal Obstetrics*, for November), writes:

The pathological conditions which pertain to the rectal tissues result in very large degree from changes in the vascularization, dependent upon the dilatation of the hæmorrhoidal veins. These are often deformed to an extent rarely appreciated by the ordinary practitioner, and only to be truly understood by the surgeon who makes the vivisection for the purpose of cure.

I am constrained to believe, as I think for abundant reason, that the ligature and cautery, destruction of the tissues by acids, etc., are not alone unsurgical and barbarous, but they also often fail in the end of securing the desired result, since a portion of the deformed structures not seldom remain unchanged, and tissues of importance to preserve are thereby frequently destroyed.

A complete dissection of the deformed hæmorrhoidal plexus, as advocated by Mr. Whitehead, offers in my judgment abundant reason for adoption, and the only criticism which I have to make upon his method is the closure of the wound with interrupted sutures. This method has been severely criticised, and has failed in great measure of general adoption because of the fear of hæmorrhage which during the indefinite past has been emphasized as liable to pertain to any of the methods applicable to the cure of hæmorrhoids. This is doubtless greatly overestimated by the profession at large.

The dilatation of the hæmorrhoidal plexus is, indeed, sometimes truly enormous, but it will be found upon dissection that the vessels quite within the grasp of the sphincter are usually very little changed, and that here their constriction is simple and easy. I have for some years operated in a way to be commended as in large measures bloodless and assuredly without danger of subsequent hæmorrhage.

The procedure is briefly as follows: The sphincter muscle is dilated and the parts put on tension by two fingers in the rectum. Either with a sharp knife or scissors division is made upon the line of the juncture of the skin and mucous membrane. With a little care the veins are separated from the loose folds of connective tissue without injury, down to the line of the sphincter muscle. They will be found closely connected with the everted thickened mucous membrane, a portion of which it is well to remove. Division should be made through it upon the line selected for excision, and a row of continuous double tendon sutures is rapidly made to encircle the base of the hæmorrhoidal plexus. It is then resected with scissors, and a light line of continuous running sutures encloses the deeper layer, and when drawn upon gently, taken, as advised, from within outward, are themselves buried, thus leaving no stitches in sight. Carefully dried and dusted with iodoform, the operation is completed by painting the line of closure with a layer of iodoform-collodion. It is usually better that three or four days elapse before defecation ensues, after which there is little suffering. With the paralyzed muscle at rest, the condition of the parts remaining aseptic, pain and edema are almost wanting.

SOME READY SURGICAL APPLIANCES.

In his address on surgery before the British Medical Association, Dr. Hingston, of Montreal (*Canada Medical Record*, August, 1892), gives some instances of the ready skill of the backwoods practitioner. We clip two paragraphs:

My predecessor in the surgical clinic, the late Dr. Munro, an eminently practical surgeon, was traveling in a wild part of the country when he was asked to see a man suffering from retention of urine. Munro had no catheter with him; many miles interposed between him and an instrument, and the roads were well-nigh impassable. He looked around the log cabin for something wherewith to enter the bladder, but saw nothing. He noticed, however, that the floor was cleanly swept, and that implied the use of a broom. He asked to see the broom. A corn broom was brought, and with it he soon entered the man's bladder. How? some will ask. With the handle? No. The corn tops? No. He had noticed that the corn tops were bound to the handle with wire; this he quickly unrolled; made a loop at the free end; and as he unrolled he straightened the wire by putting his foot into the loop; bent a piece, gave the double end a slight curve, and passed it easily into the bladder. The free ends which remained without the body separated somewhat, and the pent up fluid passed between them.

Some years I was present at a meeting of a medical society, not in Canada, it is true, but in one of the more western of the United States. A gentlemen from one of the large centres had exhibited an instrument for removing foreign bodies from the nose. He extolled its advantages, was applauded, and everything promised well. I noticed, however, a smile on the faces of many present when a small nervous man advanced somewhat briskly to the platform. I wish I could give you anything like a faithful sketch of his manner. His style was sharp, his language terse, and personal pronouns were used most sparingly. He commenced somewhat in this fashion: "Mr. President,—Much obliged to the gentleman from the city. Long distance for him to come to show us this instrument; long distance for us out here to send for one. Now, when called to see a child with a cherry or any other kind of stone, or a pea, or a bean, or a bead, or a button in his nose, not going to send all the way to the great city for this instrument, and for Professor to come with it—for that's what it means. Can do without both. Wherever there's a boy with something in his nose that has no business to be there, there is sure to be a woman in the neighborhood, and wherever there's a woman there's sure to be a hairpin. Now, with the boy and his nose and something in it and the woman and her hairpin and a live doctor and his jack-knife, nothing more is wanted. With the jack-knife half open, bend the double end, coax this bent end along the roof of the nose, raise the wrist a little, and withdraw with the bent end well down, and if one of the child's toys is there it's sure to come. Wouldn't give that instrument (he had made one while addressing us) for the instrument of the gentleman from the great city; and it don't cost as much money. There's not enough of *that* in the back-woods for the Professor."

INTRA-THORACIC AUSCULTATION.

There is a long article in the *Lancet*, November 5th, from the pen of Dr. Benjamin Ward Richardson, describing a new method of physical diagnosis. In regard to its discovery he says :

In examining a patient for digestive trouble I passed along the œsophagus a medium-sized tube and ran it without difficulty down to the stomach. There was no serious obstruction at any part, but I thought I experienced some sense of friction of a very slight kind. Whilst endeavoring to be certain on this matter an idea which I had once before had in my mind, but had not before acted upon, suddenly occurred to me. Why not auscultate through the exploring tube? At once I sliced off a portion of the upper end of the tube obliquely, slipped over this sliced end the terminal part of the double stethoscope, and made in this fashion the exploring tube a continuous stethoscope. The effect of auscultating

in this way was most interesting and satisfactory. I could hear soft friction of the tube against the walls of the œsophagus and made qnite sure that the friction was uniform throughout and that there was no special constriction or induration in any portion of the tube. When I passed the tube into the cavity of the stomach itself I obtained a sound new to me, like a gentle seething as of air or gas agitated in a thickish fluid and at times a gurgling sound of gas with another sound probably due to muscular contraction of the stomach itself. As the patient experienced no trouble or inconvenience during examination I had ample time for inquiry, and I leisurely withdrew the tube, noting the sounds audible in the course of the movement. In the tube at this time there were only two openings and those at the extreme end. I succeeded therefore in catching sounds at such points only as were in apposition to the openings. I withdrew the tube until the opening on the left side came in contact with that portion of the œsophagus that lies in immediate proximity with the heart. By previous auscultation of the heart over the thoracic wall I had failed to detect clearly the two cardiac sounds owing to the feebleness of the cardiac action, but now both sounds were as distinct as they would have been from a normal heart. They were not, however, the same precisely as the sounds we hear through the thoracic wall; they were duller in character, as if they wanted the resources which is probably produced by the pleura stretched over the thoracic cavity. At the same time they were loud and were singularly distinct. By moving the tube gently up and down I could get the second sound separately from the first and *vice versa*; but when I had the opening of the tube midway so as to compass both sounds, there was not so much difference between the first and second sound as is common to that distinguishable in ordinary auscultation. I was quite prepared for all these modifications of phenomena; they corresponded precisely with what I had learned many years ago, when in combination with the late Drs. Baly and Sibson, I had seen Dr. Halford demonstrate Brien's valvular theory of the cause of the two sounds from an opening in the chest wall of a lower animal under anæsthesia, and detected that with such immediate auscultation the sounds were deficient in sharp reasonance. and more equable in tone than was common from ordinary auscultation. It was the same now. I counted the beats of the heart very deliberately from the inside of the thorax, seventy beats per minute, the sounds and the pause in proper order and the action perfectly regular. I expected that on withdrawing the tube further out of the œsophagus it would be possible to hear a loud sibilant or vesicular murmur in respiration. In that I was disappointed to a certain extent. It was impossible to catch a murmur, even on a deep inspiration, so distinct as the murmur heard from the chest wall outside.

From these observations I have been led to the new departure in physical diagnosis in which I am anxious others should take part, and I have devoted some time to certain preliminary steps in its development. Briefly, it is a means for auscultating on an extensive scale the organs of the body *from within the body*. I shall occupy most usefully the short remaining time at my command, first, by indicating the lines of research in which the plan promises to be most useful; second, the limitations of the plan, and, if I may so express myself, the objections of it; and, third, the modes by which it may be improved from this its original start, so as to make it ready, safe and in its broadest sense useful.

The Wingah Sanitarium for Tuberculosis, Ashville, N. C., conducted by Dr. Karl Von Ruck (which was destroyed by fire some months ago), will be opened on the 20th of this month.—*New Yorker Medicinische Monatsschrift.*

Medical Items.

It is said that an infusion of chrysanthemum flowers is held in high favor by the Chinese as an eye-water.

A fatal case of tetanus following an operation for old laceration of the perineum is reported in the last number of the *American Journal Obstetrics.* As the operation was carefully done, it is supposed that the infection may have occurred from passing the finger into the rectum during the operation.

Prof. Hare says for fainting, as a rapidly acting stimulant, give alcohol, hot and concentrated. The hot alcohol acts much more quickly than cold, because the cold alcohol, before it could be absorbed, must be heated up to the temperature of the body.—*Ex.*

A new local anæsthetic has been discovered by Giesel, which he calls *tropsin.* It is produced from the leaves of the coca plant, but has no relation to cocaine. For local anæsthesia, especially in eye surgery, it is said to be preferable to the latter.—*Atlanta Med. and Surg. Jour.*

At the recent meeting of the Tri-State Medical Society in Chattanooga, Professor Richard Douglas, of the Medical Department of the University of Nashville and Vanderbilt University, was elected president of the society for the ensuing year.

A call has been issued for a conference of all the medical schools of the South, to be held in Louisville, Ky., during the meeting of the Southern Surgical and Gynecological Society, November 16th. The object of the convention is to secure concert of action among all southern medical schools towards advancing the requirements for graduation.

The Messrs. Macmillan & Co. announce that the recently completed edition of Foster's Text-Book of Physiology in four parts is to be supplemented by the issue of an appendix on "The Chemical Basis of the Animal Body," by A. Sheridan Lea, Sc. D., F. R. S. Dr. Lea is Lecturer on Physiology to the University of Cambridge, England.

At the invitation of the College of Physicians and Surgeons of Ontario, there will assemble in Ottawa representatives from the legal Medical Boards of the various Provinces. The object of the convention will be to enable the legally qualified physicians of one Province to practise anywhere throughout the whole Dominion of Canada.—*Canada Medical Record.*

Dr. W. E. B. Davis, the genial and indefatigable Secretary of the Southern Surgical and Gynæcologieal Association, has removed from Rome, Ga., to Birmingham, Ala., his former home, where, in connection with his brother, Dr. John Davis, he has established a private hospital for surgical and gynæcological work.—*Richmond Practice.*

Some of the German medical journals are agitating in favor of the compulsory cremation of all who have died of cholera, as the surest means of preventing further infection of the soil by the bacilli which their corpses contain. The health authorities of New York have disposed of the bodies of all those who have died of cholera at quarantine by cremation.—*Medical Progress.*

The proprietor of a temperance hotel who suffered from asthma, for relief used to smoke a mixture of stramonium and belladonna, which was kept in a jar in

the pantry. Recently the cook, who was preparing a goose for dinner, by mistake went to the jar and took out a large handful of the mixture and stuffed the goose with it, believing it to be sage. All who ate of it had the characteristic symptoms of stramonium poisoning—burning and dryness in the throat, dilatation of the pupils, etc. They were relieved by emetics.—*Brit. Med. Jour.*

Here is a clipping which will afford food for reflection to the cheap doctor:

Stranger (midnight)—"I should like you to go to No. 999, Suburb Avenue, to see my wife."

Doctor—"All right. I'll be ready as soon as I can get my carriage. Wait and you can ride with me."

Doctor (two hours later)—"I can see nothing the matter with your wife, except that she seems pretty mad at being waked up."

Stranger—"Remarkable recovery, I must say. Here's your dollar."

Wife (five minutes later)—"Why in creation did you bring a doctor to see me?"

Husband—"The street-cars had stopped running, and it was cheaper than hiring a cab."—*Ex.*

The College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize, being the income for one year of the bequest of the late Senor Alvarenga, and amounting to about one hundred and eighty dollars, will be made on July 14th, 1893, provided that an essay deemed by the committee of award to be worthy of the prize shall have been offered. Essays intended for competition may be upon any subject in medicine, but cannot have been published, and must be received by the Secretary of the College on or before May 1st, 1893. Each essay must be sent without signature, but must be plainly marked with a motto and be accompanied by a sealed envelope having on its outside the motto of the paper and within it the name and address of the author. It is a condition of competition that the succesful essay or a copy of it shall remain in possession of the college; other essays will be returned upon application within three months after the award. The Alvarenga Prize for 1892 has been awarded to Dr. R. H. L. Bibb, of Saltillo, Mexico, for his essay entitled: "Observations on the Nature of Leprosy."

A correspondent of the *Brit. Med. Jour.* writes: There is one point in the administration of alcohol as a medicine to which I have seen no reference, and yet one which is of great importance to the right use of the drug. Taking it for granted that the main action of alcohol is a stimulant one, and that this effect is followed by a period of depression, it is essential that we should know how long the first effect lasts with any given dose. I take it that the proper method of using the drug is to give just sufficient to produce the required degree of stimulation continuously. It seems to me that if we administer such quantities and at such intervals of time as to produce alternations of great stimulation and depression, we shall do much more harm than good. Hence the importance of the knowledge I am seeking. Has it ever been scientifically ascertained how long, for instance, the stimulating effect of one ounce of brandy lasts in a healthy man? And how this period may be altered in various diseased conditions of the body? In these days, when alcohol is used as a medicine so much more sparingly than aforetime, and when the rational use of drugs, including alcohol, is founded on a more scientific and accurate basis, it is very desirable that this question should be scientifically ascertained; or, if it had been worked out, that the knowledge should be widely disseminated.

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THE THERAPEUTICS OF ASIATIC CHOLERA.*

BY I. E. ATKINSON, M. D.,

Professor of Materia Medica and Therapeutics, University of Maryland.

(Stenographic Report by W. T. Watson, M. D., Baltimore.)

It must have occurred to most of us, in listening to the very succinct and exhaustive statements of Dr. Latimer regarding the geographical distribution of this great modern scourge of our race, with a good deal of humiliation, that the art of which we are practitioners has had very little to do in bringing about the subsidence of these various epidemics and pandemics. The epidemics seem to have spread through most countries at their own sweet will, and to have subsided for reasons which are largely beyond our powers of recognition. But while we have never had a remedy that has a definite antagonistic influence over the progress of this disease, a careful observation of the laws of hygiene places a community fairly beyond the reach of its ravages. Undoubtedly, as we all know, the number of vaunted specifics for the treatment of cholera are more than we care to consider to-night. After a brief experience with these remedies, the results of which were phenomenal in the hands of certain observers, the rose-colored reports that were given have failed to be confirmed. I will not attempt to enumerate the various specific remedies, so-called, that have been brought forward from time to time, but will begin my subject, basing my remarks upon knowledge of the disease, made more definite by the discovery of the comma bacillus by Koch,

*Read before the Clinical Society of Maryland, November 4th, 1892.

This discovery, while it has placed in our hands as yet no specific treatment, has given us very definite ideas of the difficulties we have to contend with and the indications for treatment and for the administration of remedies, if we be so fortunate as to find them. To enumerate seriatim the indications for the treatment of cholera: Our first object is the limitation of the development of the organism that is the cause of the disease; and this therapeusis is directed to the alimentary canal. The second indication is the neutralization of the poison that is produced, by the vital activity of these organisms, in the intestinal canal. The third indication is the elimination as early as possible of the poison from the blood into which it has gained access from the intestines. The fourth indication is the restoration of the blood to its normal condition, that is, to its proper degree of fluidity. It is very easy to state these therapeutic indications, but it is far more difficult to supply the therapeutic measures. Still, with the knowledge we have of the nature and the operation of the disease and the conclusions we draw with regard to the poison which the organisms produce, we are infinitely more favorably situated for struggling with the disease than we have ever been before.

In the space which I have a right to occupy, I can only say a few words in regard to the prophylaxis of cholera. That, however, is the most important aspect of the case. I shall begin with the bed-room of the patient, his house, his surroundings and the disposal of excreta. Most of this I can dispose of in a very few words because of our knowledge of antisepsis and the influence of minute organisms in the production of disease, which is the alphabet of prophylaxis. Still, it may be proper to speak a little in regard to the exact procedures that should be followed out in case of cholera in the household. The attendants of the patient should be limited. The bed should be prepared in such a way that no permanent contamination of the bedding can take place. For this purpose a waterproof blanket should be spread upon the bed and another upon the floor under it, that discharges shall not soil the carpet or flooring. The attendants should be clad in waterproof clothing. Antiseptic liquids should be at hand, and there should be a constant washing of hands. Attendants should be strictly instructed not to convey their hands to their mouths and not to feed themselves with their hands. They should use mouth washesand antiseptic solutions of weak strength snuffed into the nose. With regard to the water and food supply I should speak more definitely. Of course every one knows that the drinking water should never be used unless it has been thoroughly and recently boiled. In passing, I should say that I do not regard our Baltimore water supply as at all beyond suspicion. From my personal knowledge of the condition of Lake Roland and of its affluents and the amount of sewage and drainage that goes into it I believe that under proper conditions it may be a source of danger. The Gunpowder water supply I regard as being as nearly perfect as can be had. The water should be boiled The food of the patient should be freshly prepared and cooked. Uncooked fruits of all kinds should be avoided. Milk should be especially avoided unless recently boiled in a sterilizer. The food should be of a plain nutritious charac-

ter, but it should not be long free from the necessary amount of heat to destroy the activity of the bacillus.

Passing a little more into the specific conditions, let me say that experience seems to show that a healthy digestive apparatus is a fairly good guarantee against any attack of cholera. Those persons suffering from organic gastric derangements are the persons who are most prone to develop the symptoms of cholera so far as we know. It is claimed, I know not with how much truth, that the natural healthy acid secretion of the stomach is inimical to the development of the bacillus. It goes without saying that the excreta should be properly disinfected. For this purpose various agents are recommended. An ordinary five per cent. solution of carbolic acid seems to be most popular, and we are advised that the excreta should be allowed to remain in this solution for some time before thrown out. Ordinary commercial sulphuric acid, three or four drachms to be added to each stool, is recommended. The various corrosive sublimate solutions can be employed.

Suppose the precautionary measures have been unavailing and we have the patient in the condition of preliminary diarrhœa of cholera. This is an uncertain condition. Unquestionably in cholera epidemic diarrhœas are very prevalent. Often they are of no consequence; often after a time they develop into true cholera. The outcome we cannot always foretell, and we should carefully treat the diarrhœa. Nearly all recommendations for treatment of this preliminary diarrhœa include opium. This seems to have been a universal practice and unquestionably it is an excellent practice in the ordinary diarrhœas which may not be choleraic; but whether this plan of treatment is efficient in true choleraic diarrhœas is a point upon which I am not prepared to speak with conviction. Certain it is that nearly all observers at the present time condemn opium in the treatment of cholera; not hesitating to use it to relieve extreme pain; but as a remedy for the treatment of cholera itself it is condemned. I read recently an article by Sir George Johnson, in which he observed that in some of Koch's experiments he was not able to produce cholera in rabbits experimentally until he had first given them opiates. At all events whether the use of opiate preparations in the preliminary diarrhœa of cholera is to be recommended or not, there seems to be almost a universal sentiment amongst recent observers that opium is not the proper remedy to employ in the developed disorder. Many authorities recommend that the preliminary diarrhœa of cholera should be treated by purgatives and that if opium is given in those cases it should always be in association with a purgative, and experience seems to show that castor oil is the most efficient of these. The castor oil is given with more or less persistence during the treatment of the diarrhœa. Of course the patient should be kept in bed until the diarrhœa is cured.

The use of acids has been very much recommended in these preliminary conditions. It is claimed that the acid condition of the stomach is inimical to the development of cholera and it has seemed that this antagonistic condition of the

stomach might be increased by giving the proper acid; therefore small doses of hydrochloric acid and other mineral acids are given and with a fair degree of justification. But these are merely accessory means for combating the choleraic diarrhœa in the initial stage.

I mention now a drug that has been recently recommended as a specific for cholera; and certainly if we could rely upon the statements (but we all know how unreliable statements made from a few observations are) we well might suppose that in this remedy we have one that has a specific influence in antagonizing the poison. This drug is salol. Lowenthal has extolled its use. Gonzales lost only three patients in fifty-three cases of cholera treated with salol. Nicholson treated thirteen cases; all recovered. Hehir treated eighteen cases with corrosive sublimate with a mortality of 44.7 per cent.; eleven with salol without a death. If the list went on as it begins we would have every hope of having a specific in cholera as we have a specific in malarial fever or syphilis or acute rheumatism; but recent reports, especially from the hospitals of Hamburg, during the recent epidemic, from a number of physicians, declare that salol gave no good results whatever in their hands. While at the present time we are not prepared to deny a specific influence to salol we are not prepared to accept it as a specific or a remedy that exerts a pronounced influence over the course of the disease. It undoubtedly has a disinfecting influence on the intestinal canal and I am inclined to think that I will use it if I have to treat cases of cholera.

Death in cholera seems to be due, first of all to the loss of fluid from the body, and in the second place to the chemical substance generated by the bacillus, which acts as a poison on our bodies. Now, the effort to meet this indication has called forth certain novel methods of treatment which seem to promise a great deal. The practice of what is called "enteroclysis" it is claimed gives marked results in the treatment of cholera. This practice has its greatest advocate in Cantani, of Naples, although he was not the first to practise it. It has received its highest praise from him and its most extensive application has come from his description of its use in this disease. He claims under this enteroclysis and the method of injection of a saline fluid under the skin—hypodermoclysis—to have had 70 per cent. of recoveries. What is enteroclysis? We are told that in the very early stages of cholera there should be injected into the rectum a fluid containing tannic acid, because this acid exerts an astringent influence on the mucous membrane of the bowel and also has a destructive action upon the vitality of the bacillus. From five to twenty grammes should be used to the liter of water, or from 75 to 300 grains to the quart of water, at a temperature of two or three degrees above the normal temperature of the body. The injection is allowed to run in slowly and is frequently repeated. This succeeds in washing out to a considerable extent the large intestine, and Cantani claims—and there I think we will be disposed to question the accuracy of the claim—that the fluid goes beyond the ileo-cæcal valve. I doubt whether the

liquid can be made to reach beyond the ileo-cæcal valve, or, if so, in more than very small quantities. This doubt cannot but make us feel some hesitation as to the accuracy of other statements. At first this solution of tannin was made in infusion of chamomile. I do not think that any one can claim any specific virtues for the chamomile and it seems to me that, as in the treatment of cholera we should lay aside everything that will embarrass our action, we should dispense with it. Then, too, a certain amount of tincture of opium, 30 to 50 drops, may be added to the injection. But so far as I can discover, the essential agent is a solution of tannin in warm water. As the algid stage comes on and the patient begins to lose by vomiting and purging, enormous quantities of water and fluid, this enteroclysis is supplemented by hypodermoclysis. Thisconsists in introducing under the skin a solution of common salt, the normal salt solution of about .75 per cent., or one may use a teaspoonful in a quart of water. According to Cantani's recommendation it is combined with carbonate of sodium. One may use a drachm of chloride of sodium and forty-five grains of carbonate of sodium to a quart of water at 39 degrees centigrade. This is introduced by means of a cannula into the subcutaneous tissue and usually in the ileo-costal region. The cannula is introduced; the fluid is allowed to run in under gentle pressure through tubes and vessels that have been carefully antiseptisized. The pressure is so gentle that it will take from 30 to 50 minutes to run in. Instead of having only one cannula, it is desirable to divide the fluid into equal quantities and run it into differerent parts of the body. This forms a tumiscence, which gradually disappears. This method, it is claimed, and especially in the Hamburg hospitals during the last epidemic, has done marvels and has brought people right up from the very jaws of death. But further observations amongst those who practised amongst the cholera patients in Hamburg seems to place the intravenous injection of this fluid above the hypodermoclysis. Quite a number of physicians have concluded that intravenous injections produced results marvelously greater than those of the hypodermic injections. I remember a statement that one physician made that where a patient had been brought out of a state of collapse by the intravenous injection of the saline fluid, and falling again into collapse, the hypodermic injection did not succeed in restoring him as the intravenous injection did, while the intravenous injection again and again would bring the patient out of this condition. It seems from a purely theoretical point of view that those intravenous injections should not produce results so marvelously better than the other. By this method one runs the risk of thrombosis and of introducing other substances into the veins. Such results, however, did not occur in Hamburg. If there is any power of absorption in the connective tissues at all, and if it can be shown that this fluid is taken up, it would not seem reasonable that there should be this marvelous difference. When the algid state is over and the patient passes into the typhoid state of cholera, it is recommended that enteroclysis be again resorted to, not with tannic acid, but with saline solutions, for the purpose

of restoring the blood to its proper condition. These solutions may begin with from two to five grammes to the liter or one to two drachms to the quart, and they may be increased until the proportion of salt in the solution may approach fifteen or twenty per cent. This should be used along with the hypodermoclysis or intravenous injection of the saline fluid. Recently arterial injection has been recommended, but I have not been able to find any reliable data about it and therefore I only refer to it.

This constitutes what seems to be the most promising treatment of Asiatic cholera, and nearly every one who has practised it speaks of it in terms of praise.

I want to refer again to the point that opium not only seems not to have a beneficial, but to have a positively meretricious influence over the course of Asiatic cholera. I wish to refer again to the statement that the results in the treatment of cholera in earlier years when calomel and castor oil were used appear to have been better than they were under the treatment by opium. Certainly the results of treatment of cholera in earlier years by calomel and castor oil appear to have been better than those of treatment by opium. Certainly the treatment of cholera by opium and by the various mineral and vegetable astringents does not give a percentage of cures that in any degree encourages us to persevere in their use.

The procedure proposed is certainly worth careful investigation and I am sure that if I were called upon to treat cases of cholera to-morrow I should at once put this method of treatment into practice.

PRACTICAL EXPERIENCE WITH DILATING URETHROTOMY IN STRICTURE.*

BY CHARLES F. BEVAN, M. D.,

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It has occurred to me that the present occasion might not be an inappropriate one to review the much discussed question of urethral strictures treated by dilating urethrotomy, and to note some of the results obtained by this method. Such a review seems the more desirable now, inasmuch as there exists a very wide-spread notion that in electrolysis we at last have a method, safe, sure, more expeditious, and more lasting.

It is not the purpose of this paper to contrast the two methods of treatment, the time for that hardly having yet arrived, but rather to see how time has sustained the claims of Professor F. N. Otis, made in 1870. Briefly stated these claims were:

1st. As to the normal calibre of the urethra.

2nd. That a definite proportionate relation existed between the circumference of the urethra and the organ in which it is situated.

3rd. The importance of recognizing the possibility of stricture of a calibre above the then usually accepted standard normal size of the urethra.

*Read before the Medical and Chirurgical Faculty of Maryland, at Easton, Nov. 16th, 1892.

4th. The common dependence of gleet and often of troublesome reflex irritations upon such strictures.

5th. The great frequency of stricture in the anterior part of the canal.

6th. The possibility of a radical cure of stricture by dilating urethrotomy, and the great advantage of such an operation over the dilating procedure both in regard to safety, comfort, time and permanency of results.

Prior to the publication of Dr. Otis in 1870, the standard size of the urethra accepted as normal was 8 or 9 E. or 21 F. If a sound of such a size could be made to traverse the urethra without giving much pain, or drawing blood, that fact alone was relied upon as absolutely excluding a stricture. The proposition of variations and differences in the size of the urethra, variations as great in this member as in any other of the body, awakened a storm of opposition. The announcement was received in any other than a scientific spirit; and when, during the argument, Dr. Otis claimed the normal urethra to be a canal of almost uniform calibre, the abuse, censure and ridicule heaped upon his defenseless head almost passes belief. It is said that in New York the penis and urethra were more closely studied than ever before, so much so indeed that it was impossible to find a cadaver in the city that had not been mutilated in the vain efforts to overcome what was considered a too radical departure from authoritative traditions. How stands this question to-day? Are surgeons satisfied that their full duty has been discharged, when they can easily pass an 8 or 9 E. or 21 F. sound? Do the local disorders of a strictured urethra subside and remain quiet when the calibre of the urethra is not more than 21F.? Are surgeons, generally, able to verify the claim of a much greater size than the standard 8 or 9 E.?

In August, 1880, Sir Henry Thompson, who had rather strongly discountenanced the new theory and operation, said to the members of the British Medical Association, "It is now generally accepted that dilatation of strictures can be carried with safety and advantage to a higher degree than was formerly considered admissible." Mr. W. F. Teevan, the Lettsomian lecturer of 1880, says (*Lancet*, January 24th, 1880, page 21): "He (Dr. Otis) has shown us that we had greatly under-estimated the calibre of the urethra, and what good results we shall obtain if we raise our standard in the treatment. Let us not forget that without Dr. Otis there would probably have been no Bigelow. Dr. Otis demonstrated what large instruments could be passed down the urethra, and Dr. Bigelow utilized the discovery for his new method of lithotrity." I am sure the sentiment of the profession is hardly doubtful upon this claim. In a series of 500 measurements carefully made with the urethra-meter and bulbous sounds, I found but one case in which the calibre was below 26 F. and one in which the urethra was so capacious that a 47 F. sound glided of its own weight smoothly and painlessly along the entire urethra. The general average of my series equalled 32 F. and that I feel sure is the experience of those who have made careful observations.

The old rule that any instrument that can be passed through the *meatus* will be large enough to traverse the urethra, to a limited extent may still be consid-

ered as true, but it by no means follows that such an urethra is free from contractions. Undoubtedly from a variety of causes, local inflammations, sores, etc., and perhaps, too, from inheritance, the meatus has become the narrowest part of the canal, being generally from 2 to 4 or 5 mm. smaller than the remainder of the canal. That a definite, proportionate relation between the circumference of the urethra and the organ in which it is situated exists, is, I know, not accepted by every one. I am quite sure, however, that any one who will make 100 or more measurements, taking the circumference of the organ in its flaccid state and carefully recording the observations, will be thoroughly astonished at the results. He will be perfectly willing to admit that if not absolutely true, the circumference of the penis affords a far more accurate rule for the selection of the proper sized instrument to be used than the size of the meatus. So frequently do I find the measurements of the penis confirmed by the urethra-meter and bulbous sounds as to the calibre of the urethra, that I can not accept the results as being merely accidental, or mere coincidences, and yet I can give no anatomical reason for the existence of the claimed proportionate relation.

The importance of recognizing strictures of large calibre (that is, of a size beyond the 8 or 10 E, the old standard size of the urethra), the very common dependence of gleet and frequently of troublesome reflex irritations hardly needs more than a passing glance. If urethral contractions even produce any detrimental or pernicious effects, either upon bladder, ureters or kidneys, the sooner such causal agents are recognized and treated the better for the patient's interests. Large size strictures sooner or later become small ones; and apparently innocent or trivial lesions too frequently become the starting point for serious illnesses.

Urethral contractions are due in the majority of instances, to the urethral inflammations, and inasmuch as the chief cause of this inflammatory process seems by preference to select the anterior portion of the urethra, it is there that we find the largest number of strictures.

An analysis of my own cases, now above 500, shows that of 1088 contractions, including those of the meatus, 982, or 90 per cent., were located in the anterior $4\frac{1}{4}$ inches of the urethra; and 106, or 10 per cent., were found between $4\frac{1}{4}$ and $7\frac{1}{4}$ inches.

In the "*Medical Chronicle*," October, 1882, I reported a series of 200 cases. These, and 300 new cases, arranged in series of 100 each, show:

First Series of 100 *Cases.*

Location.

Anterior,	$\frac{1}{4}$ inch,		38
Between	$\frac{1}{4}$ and $1\frac{1}{4}$ inch,		47
"	$1\frac{1}{4}$ " $2\frac{1}{4}$	"	51
"	$2\frac{1}{4}$ " $3\frac{1}{4}$	"	50
"	$3\frac{1}{4}$ " $4\frac{1}{4}$	"	14
"	$4\frac{1}{4}$ " $5\frac{1}{4}$	"	11
"	$5\frac{1}{4}$ " $6\frac{1}{4}$	"	9
"	$6\frac{1}{4}$ " $7\frac{1}{4}$	"	5
			225.

Second Series of 100 *Cases.*

Anterior,	¼ inch,	41	
Between	¼ and 1¼ inch,	45	
"	1¼ " 2¼ "	50	
"	2¼ " 3¼ "	48	
"	3¼ " 4¼ "	15	
"	4¼ " 5¼ "	9	
"	5¼ " 6¼ "	7	
"	6¼ " 7¼ "	6	
		——	221

Third Series of 100 *Cases.*

Anterior,	¼ inch,	40	
Between	¼ and 1¼ inch,	46	
"	1¼ " 2¼ "	48	
"	2¼ " 3¼ "	48	
"	3¼ " 4¼ "	16	
"	4¼ " 5¼ "	10	
"	5¼ " 6¼ "	5	
"	6¼ " 7¼ "	5	
		——	218

Fourth Series of 100 *Cases.*

Anterior,	¼ inch,	36	
Between	¼ and 1¼ inch,	42	
"	1¼ " 2¼ "	47	
"	2¼ " 3¼ "	47	
"	3¼ " 4¼ "	16	
"	4¼ " 5¼ "	10	
"	5¼ " 6¼ "	6	
"	6¼ " 7¼ "	3	
		——	207

Fifth Series of 100 *Cases.*

Anterior,	¼ inch,	38	
Between	¼ " 1¼ inch,	42	
"	1¼ " 2¼ "	50	
"	2¼ " 3¼ "	48	
"	3¼ " 4¼ "	19	
"	4¼ " 5¼ "	10	
"	5¼ " 5¼ "	8	
"	6¼ " 7¼ "	2	
		——	217

Total, 500 *Cases,* 1088 *Strictures.*

The *curability* of urethral stricture is still a mooted question to many of the profession. It is certain that the older methods of treating this malady, viz., by dilatation, divulsion, cauterization and electro-cautery, do not afford satisfaction. Patients so treated are often improved for a while, but sooner or later, weary of the necessary routine under which they must live, they become careless and neglectful, and only become roused again to action by an attack of retention of urine; it is then found that recontraction has occurred, often to a degree greater than primarily existed. Dilating urethrotomy, when properly prac-

tised gives unquestionably far better results. A certain number of positive cures can be expected from it. I have been able to carefully re-examine 123 of the 500 cases here reported, with the result of finding recontractions in 5. These examinations were made at intervals following the operation of from 8 months to 9 years. In 1882 I collected from various sources 311 cases operated upon, of which number 105 had been carefully re-examined without finding any evidence of re-contraction. If to this number we add the series here reported it will show 811 cases, 228 re-examinations and only 5 re-contractions; thus 228 out of 811 cases may be reasonably classed as cures, since re-contractions were not discoverable with the urethra-meter and bulbous sound, and the time interval after the operation was amply sufficient for such changes to have occurred. The small number of re-contractions found (5) may be accounted for either by imperfect operation, failing to cut deep enough, or by some new inflammation producing re-contractions. No other method of treatment has ever yielded me results at all comparable to this. Many of my cases have been drawn from the out-door department of a large hospital, and hence cannot be followed up as desired. The fact, however, that they do not report for treatment of their strictures is rather favorable to the belief that they no longer suffer from them. It is important, in cutting, to cut freely; as Sir Henry Thompson happily expresses it, "If you cut at all, cut all." Unless section be made *entirely through* the narrowing bands re-contractions are found to return, and are then often more narrow than at first existed. It is a safe practice to cut 2 or 3 sizes beyond the normal calibre of the urethra, and to verify the freedom of the cut by using either the urethral-meter or bulbous sounds after the operation. If resistance is then encountered, cut again, and repeat the measure until the sound passes freely. It has more than once occurred to me to cut 4 or 5 times before sufficient freedom was obtained. I have never had occasion to regret the great care given to this feature of the work, but have been mortified by failures when it was neglected. Dilating urethrotomy is as safe, if practised as recommended by the author of the method, as any other plan; it is more expeditious and the results are in my judgment more satisfactory. No deaths have occurred from it in my hands, and the mortality belonging to the operation is not larger than that ordinarily attributed to passing a catheter. Hæmorrhage has been held up as a bugbear by some opponents of the operation, and in the early history of the procedure, I believe some trouble was experienced from this source. The precaution should always be taken to make the incisions carefully in the median line and upon the upper wall of the urethra, and to compress the penis by a broad (2 or 3 inch) bandage after the operation. I have followed this practice for years and have never been annoyed by any troublesome bleeding, or been obliged to resort to the perineal crutch to control hæmorrhage. Dilating urethrotomy is of course chiefly applicable for those contractions met with it in the ante-bulbous portion of the urethra. I have, however, resorted to it with most satisfactory results for those met with in the deep urethra; thus between 4¼ and 7¼ inches, 106 contractions

were noted, or between 5¼ and 7¼, 56 contractions. While success may attend the operation when applied to the deep urethra, the special scope for it is undoubtedly the anterior 4 or 5 inches. It is safer to practise dilatation alone or perineal section when the stricture is deeply located.

Urethral or catheter fever is an accident very likely to follow. I have often experienced considerable anxiety from this source. It has been a routine practice with me to give 10 grains of quinine and ¼ grain of morphine immediately after the operation. I am sure benefit has been derived from the practice and often the chill has been prevented. Of late I have freely washed out the urethra with the birchloride solution, 1:10,000; cases of fever are not quite so numerous, and with more complete antisepsis the results will doubtless be more and more satisfactory.

MEDICAL TREATMENT OF RECTAL CANCER.

The question of medical treatment of cancer of the rectum, in contra-distinction to surgical procedure, is an interesting one, seeing that the latter is of so little promise in many cases and that a very short immunity only from recurrence is obtained after running the gauntlet of a severe surgical operation. For such cases, where the disease is advanced and the progress slow, M. Dujardin-Beaumetz has devised a plan of treatment of which he reports favorably and which he credits with being able to prolong the patient's life longer than could be hoped for after an operation, even when successful. With this end he has recourse to intestinal washings with antiseptic solutions, so as to arrest, or at least diminish, the progress of the malady by removing the pus and secretions frequently. A solution of naphthol—ten to twenty centigrammes per cent.—is what he advises. In addition to this he disinfects the intestinal canal by exhibiting salol or benzonaphthol with bicarbonate of soda, in wafers by the mouth. Laxatives must also be given to prevent any accumulation in the colon, and M. Beaumetz is of the opinion that a diet consisting largely of vegetables is also advisable. He has at present under observation three patients suffering from rectal cancer who for the last three years have been subjected to this method of treatment and who have even gained in flesh. He is satisfied that the method is superior to extirpation. —Paris correspondence of *Lancet*.

ANEURISM OF THE BASILAR ARTERY IN A BOY SEVEN YEARS OF AGE.

Oppe (*Münchener medicin. Abhandlung*) has reported the case of a boy, seven years old, who when three years old received a self-inflicted blow upon the head from a hammer. Considerable hæmorrhage ensued, but the child apparently recovered perfectly. Four years later, much pain appeared in the abdomen, at the nape of the neck, radiating in the length of the spine and in the throat. The breathing assumed the Cheyne-Stokes character; the action of the heart became irregular. There was some spasm of the extremities. Subsequently there appeared sopor, headache, and cardiac arrhythmia, death finally taking place. At the autopsy the basilar and the vertebral arteries were found the seat of aneurism. There were, besides intermeningeal hæmorrhage, internal hydrocephalus and pleural adhesions upon the left.—*Inter. Klin. Rundschau*, 1892, No. 34, p. 1404.—*Med. News*.

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BALTIMORE, NOVEMBER 26, 1892.

Editorial.

OUR WEEKLY CHRONICLE.

THE FACULTY MEETING AT EASTON.

The semi-annual meeting of the Medical and Chirurgical Faculty was held in Easton, Talbot County, on the 15th and 16th of the present month. and is on all sides declared to have been a great success. The sessions were held in the court-house and were well attended and full of interest, although the weather on Tuesday was disagreeable and probably hindered many county members from coming.

The session of Tuesday was opened by a very appropriate address of welcome from Dr. Edward R. Trippe, of Easton, to which the President, Dr. Tiffany, responded, laying stress upon the desirability of uniting all physicians of good standing in the membership of the Faculty. Papers were read by Drs. Wm. T. Howard, Jr., on "The Amœba Coli; Its Importance in Diagnosis and Prognosis;" W. B. Platt, on Modern Treatment of Club-Foot, Illustrated by Casts and Cases; John N. Mackenzie, Remarks on the Nose, with Classical References, and also a Résumé of the Treatment of Nasal Occlusion; S. K. Merrick, on the More Common Forms of Nasal Stenosis; Hiram Woods, The Importance of Determining the Cause of Repeated Attacks of Earache which Subside Apparently Without Injury to the Ear; S. T. Earle, on a Successful Case of Colectomy for Closure of an Artificial Anus; W. B. Canfield, on the Importance of Symptom Treatment in Pulmonary Consumption; J. Whitridge Williams, on Genital Tuberculosis in Women; its Frequency and Clinical History; Robert T. Wilson, on Circumscribed Peritoneal Dropsy Simulating an Ovarian Tumor.

There were present on the first day forty physicians, including Drs. E. R. Trippe, John C. Earle, Charles Lowndes, Lloyd Smith, Julius A. Johnson, Jas. H. Anderson, James M. H. Bateman and J. E. M. Chamberlaine, all of Easton; Dr. Charles M. Ellis, of Elkton; Dr. James Bordley, of Centreville; Dr. James

A. Stevens, of Oxford; Dr. John S. Fulton, of Salisbury; Dr. Monmonier Rowe, of Deal's Island; Dr. S. J. Windsor, of Dame's Quarter; Dr. R. Dashiell, of Princess Anne; Dr. James Seth, of St. Michaels; Dr. Thomas H. Brayshaw, of Glen Burnie, Anne Arundel County; Dr. E. M. Hardcastle, of Trappe; Dr. Charles Rose, of Cordova; and Dr. (?) Thomas Martin.

Baltimore was represented by Drs. L. McLane Tiffany, Robert T. Wilson, John N. Mackenzie, S. K. Merrick, Wm. B. Canfield, J. Whitridge Williams, Wm. T. Howard, Jr., Walter B. Platt, Amos L. Gage, W. Guy Townsend, T. A. Ashby, Hiram Woods and Samuel T. Earle.

The papers read on the second day were: Observations on the Relations of the Organs of Reproduction to Cerebro-Spinal Disturbances in Women, by Dr. T. A. Ashby; The Radical Cure of Hernia, with Exhibition of two cured patients, by Dr. W. S. Halsted; Some Minor Therapeutic Uses of the Galvanic Current, by Dr. A. K. Bond; Operation for Removal of Peach-stone Lodged in the Œsophagus, by Dr. J. M. T. Finney; Localization of Tumor of the Brain, with specimens, by Dr. George J. Preston; Report on Head Injuries, by Dr. I. R. Trimble; A Short Study in Clinical Obstetrics, by Dr. Fred. Dunning; The Therapeutics of Epilepsy, by Dr. Samel J. Fort; Dilating Urethrotomy, by Dr. Charles F. Bevan.

At the session of Wednesday there were forty-five physicians in attendance, including Dr. Samuel C. Trippe, of Royal Oak; Dr. Eugene Douglass, of Oxford; Dr. C. M. Stille, of Cordova; Drs. J. McCormick and T. W. Greenley, of Trappe; Dr. Samuel J. Fort, of Ellicott City; and Dr. Fred Dunning, of Easton.

The Baltimore delegation included Drs. I. R. Trimble, C. F. Bevan, A. K. Bond, J. M. T. Finney, Wm. S. Gardner, W. S. Halsted, Wm. E. Moseley, George J. Preston and Nathan R. Smith.

The average excellence of the papers was very gratifying and they were well received and fully discussed by the audience, all medical visitors being invited to participate.

Dr. Julius A. Johnson, of Easton, presented to the Faculty for its library a large Atlas of Obstetrical Plates, published in 1774, in England, by Dr. Hunter; the plates being from copper plates of very skillful workmanship.

Messrs. Dawson and Jenkins, of Easton, presented to the Faculty a pamphlet of 78 pages, by E. Martin, M. D., of Easton, published in 1815, concerning the epidemics of the winters of 1813 and 1814 in Talbot and Queen Anne's Counties.

Petitions were signed asking an appropriation from our National Congress for the Pan-American Medical Congress.

A banquet was held on Tuesday evening in the Hotel Avon, which was largely attended and much enjoyed. Smaller parties of guests were entertained on Wednesday evening by Drs. J. M. H. Bateman and John C. Earle. The return trip by steamboat was enlivened by an oyster feast supplied by Dr. Trimble.

The thanks of the Faculty are due to the physicians of the Eastern Shore and the people of Easton for their interest in the meetings and the cordial welcome which they extended to the visitors from across the Chesapeake.

The general sentiment of the guests was, "We had no idea before what an attractive town Easton is."

There was serious complaint against the management of the meeting because commmutation rates were not secured from the steamboat companies and the hotels.

Reviews, Books and Pamphlets.

International Clinics. We have received from the J. B. Lippincott Co., Philadelphia, the generous gift of the three last volumes of the first series of "*International Clinics,*" which is a quarterly of clinical lectures on Medicine, Surgery, Gynæcology, Pediatrics, Neurology, Dermatology, Laryngology, Ophthalmology, and Otology, by professors and lecturers in the leading medical colleges of the United States, Great Britain and Canada, edited by JOHN M. KEATING, M. D., of Philadelphia, editor of the excellent and well known *Cyclopœdia of Diseases of Children*; J. P. Crozer Griffith, M. D., Professor of Clinical Medicine in the Philadelphia Polyclinic; J. Mitchell Bruce, M.D., F. R. C. P., London, Lecturer on Therapeutics at the Charing Cross Hospital, London; and David W. Finlay, M. D., F. R. C. P., Aberdeen, Scotland, Professor of Practice of Medicine in the University of Aberdeen.

This first series runs from April, 1891, to January, 1892, inclusive; the second series beginning in April, 1892, and covering one year. The work is a very attractive one, giving lectures by able men upon a great variety of subjects, in such a way as to constitute a series of brief clinical monographs, by home and foreign teachers, on subjects of deep interest to the practitioner. These are arranged in groups according to their subjects. In one volume alone of this first series there are 43 such articles, covering, with the index, 382 octavo pages.

Geographical Pathology, an inquiry into the Geographical Distribution of Infective and Climatic Diseases. By ANDREW DAVIDSON, M. D., F. R. C. P., Ed., Late Visiting and Superintending Surgeon, Civil Hospital, and Professor of Chemistry, Royal College, Mauritius. Cloth, pp. 1,000, $7.50. In 2 octavo volumes. New York: D. Appleton & Co., 1892.

The object of the work is to sketch the geographical distribution of infective and climatic diseases, and to trace the influence of temperature, rainfall, altitude and soil-conditions on their prevalence, character and epidemic spread. Each country or region in the world is taken up in turn, a brief consideration of its physical conformation and other conditions which might influence disease is given; and then the prevailing diseases of the above mentioned classes are discussed one by one, sometimes briefly, sometimes at considerable length, according to their importance and the amount of available information concerning them.

The statistics of mortality are given as far as possible. Variations in the intensity of the disease; and in some cases, as in syphilis, the acquisition by a merely inoculable disorder of infectious characteristics, are among the interesting points to be learned from a perusal of the work. It deserves a place in the practitioner's library.

Reports from the Consuls of the United States; No. 143, August, 1892; Washington: Government Printing Office.

This series of monthly Government publications is well worthy of the interest of every physician. It furnishes most interesting current reports on the most important commercial matters of each nation of the world, with here and there articles, simple or elaborate, of a character to interest any thoughtful person, whatever his calling in life. We frequently present our readers with extracts from their pages.

A Text-Book of the Principles and Practice of Medicine. By HENRY M. LYMAN, M. D., Professor of the Principles and Practice of Medicine, in Rush Medical College, Chicago. In one very handsome octavo volume of 926 pp., with 170 illustrations. Cloth, $4.75; leather, $5.75. Philadelphia: Lea Brothers & Co., 1892.

Professor Lyman, widely known as an eminent physician, teacher and author, has included in this volume not only the fruits of his own long experience, but likewise the results of the latest researches at home and abroad. His work has been cast in a form which renders it well suited to the wants both of students and practitioners.

We find in this volume a very concise review of the whole field of practice of medicine, the aim of the author being to present a framework which the future physician can clothe with the results of subsequent reading and observation. The physician cannot depend upon it as his only text-book on practice, for its suggestions concerning treatment are brief to barrenness and wholly insufficient to meet the daily difficulties of medical practice. As a "framework" or outline to be filled in from other books, however, it does very well, and therefore we may congratulate the author on his successful work.

The U. S. Pharmacopœia, 1890, which will be published during 1893, adopts in great measure the *metric system* of weights and measures; this will doubtless create much confusion in the minds of physicians and druggists, and lead to many misunderstandings and errors. In order to provide a guide to the proper dosage, etc., Dr. Geo. M. Gould, author of "The New Medical Dictionary" prepared a very complete table of the official and unofficial drugs, with doses in both the *metric and English* systems; this table is to be published in P. Blakiston, Son & Co.'s Physicians' Visiting List, for 1893, together with a short description of the metric system.

Medical Progress.

SYMPTOMS OF SYPHILITIC BRONCHO-STENOSIS IN CHILDREN.

Dr. Seibert, of New York, writes (*Archives of Pædiatrics*, Nov.) in a somewhat extended paper on this subject:

Within the last three years four little patients have been under my treatment, presenting such analogous evidence of disease, that I may safely condense their histories into one. These children were one-and-a-half to three-and-a-half-years of age. In all the trouble was chronic, having lasted three, four, five, and eight months, when first seen by me. Cough, later hoarseness and aphonia, were the primary symptoms. Then short breathing and occasional dyspnœa were noticed, gradually becoming more frequent, till at last, a barking, croupy cough, associated with more or less severe attacks of dyspnœa, would take up most part of the night, relief only coming after copious expectorations of mucus. Thus

gradually a condition developed itself, which at times closely resembled empyema and asthma, and again at others appeared to be identical with acute laryngeal stenosis. In two of these cases, the youngest child of twenty months and the oldest of three-and-a-half years, the croupy character of the trouble was more conspicuous, while in the symptoms of the other two patients the respiration presented more of an asthmatic variety.

The physical examination of the thorax evinced the following conditions: Very marked respiratory excursions of the entire thorax. Deep retraction of the suprasternal and supraclavicular fossæ of the intercostal spaces, and marked peripneumonic furrow. The action of the right half of the thorax is less marked and slower than that of the left half. The pectoral fremitus is diminished posteriorly on the right side. *Percussion* brings forth nothing abnormal over the right lung, corresponding to the middle lobe, one, and in two cases two areas of dulness are found irregular in circumference, but corresponding in being broad below and narrower at their upper termination. In no case did this dulness extend to either the base or the apex of the lung.

Over the entire left lung *auscultation* reveals normal vesicular breathing and loud bronchial respiration transmitted from a distance. *Over the right lung vesicular breathing is entirely absent*, and in its stead sharp bronchial stenotic in- and expiration is heard, mostly marked in front and behind the upper half of the right side, and with this large and small moist rales over the dull area.

Oral inspection always reveals granular swelling of the mucous lining of the lower pharynx, yellow, purulent secretion from the larynx and trachea, and in the oldest child, papulous ulcers and gummous infiltrations of the tongue and pharynx. Moderate multiple glandular infiltration of the neck and groin. Purulent discharge from the nose. Somewhat puffy face. No cicatrices. Fairly nourished general condition. *Temperature normal.* Pulse very rapid. Respiration irregular and slow. Stenotic respiration sometimes very loud, less marked at others. Digestion, bowels and appetite in order.

DIABETES INSIPIDUS IN CHILDREN CAUSED BY HOT WEATHER.

When in Calcutta in May, I visited the General Hospital there, and through the kindness of Surgeon-Major Crombie I was enabled to take the following notes of four cases of diabetes insipidus.

The disease occurs in India in the hot season, previous to the bursting of the monsoon, and lasts from some weeks to months; it does not seem to cause any permanent injury to the constitution of the child. In spite of a high fever of a constant type, with passing of an immense quantity of water, the little patient keeps in fairly good general health, and presents nothing abnormal in any organ. The exact etiology of this disease is still vague. This diuresis of a large quantity of limpid urine of a specific gravity little above that of ordinary water seems to be synchronous with the fever. The treatment in every case is the administration of the tincture of belladonna pushed to complete dilatation of the pupils. This cures both fever and diuresis, which pass off never to recur or in some cases to return next hot season.

Case I. Was that of a male child two years and six months old. When I saw him he had been in the hospital one week. The fever commenced a week previous to his admission to the hospital, and been preceded one day by the diuresis, according to the mother's statement. Fever, 100° to 102°F.; sometimes the temperature fell to normal. Occasionally 100 or more ounces of water were passed in the twenty-four hours, the specific gravity being 1,002; except for a little bronchial catarrh the child was healthy; it was improving under fifteen minims of belladonna daily.

Case II, also a male, nine months old. He had had fever and diuresis for thirty-one days, and had been in the hospital for four days. The fever varied between 99° and 102°F. His mother said she noticed that he had fever and passed large quantities of water; at the same time all his organs were normal. A brother, aged five years, when two years old was attacked in the same way, and had the diuresis for nine months. Treatment was the same as in the last case.

Case III was that of a female child who was in fairly good health and had a good appetite but very great thirst. She was about twenty months old. The fever commenced with diuresis a fortnight before admission. The fever, which had lasted twenty-seven days, kept between 100° and 102°F., generally rising in the morning. All the organs were normal; no diarrhœa or constipation. She was taking one minim of belladonna every two hours.

Case IV presented nearly the same features as the others. The patient was a male, one and one-half years old, who had had fever for fourteen days previous to admission. The fever varied between 100° and 102°F. The boy was very thirsty and drank a large amount of water. The urine was passed continually. It was limpid and almost colorless, but owing to his age the amount could not be properly estimated.—Dr. Brunton, *British Medical Journal.*

THERAPY OF CODEINE.

In a discussion before the Academy of Medicine, Dr. Longfellow (*Cincinnati Lancet-Clinic,* November, 1891) said:

Codeine is most useful as a remedy in both extremes of life, which do not bear opium as well as those of middle age. I have used codeine with fair success in those cases where other preparations of opium have produced delirium or aggravated the already existing condition of excitement. In the cough of phthisis, especially the latter stages, I have found codeine, combined with oleo-resinoid of cubeb, of great service. In chronic bronchitis, combined with terebene or grindelia robusta, codeine has given fair results. I have used codeine combined with extract of hyoscyamus to good advantage, by suppository, in dysmenorrhœa and pelvic cellulitis. In cases of insomnia, codeine alone, or combined with chloral or the bromides, has given better results than morphine; while the latter is the greater anodyne, codeine is preferable as a hypnotic. In the treatment of diabetes, codeine, as well as other alkaloids of opium, has given good results, but the remedy must be given in full doses to produce and maintain a decided benefit. In my own uses of codeine, I have found it to act better when combined with synergistic remedies, than when administered by itself.

A PECULIAR OCCUPATION-NEUROSIS.

Tranjen (*Berliner klin. Wochenschr.,* No. 33, pp. 838) has reported the case of a military officer, twenty-seven years old, who presented a peculiar spasmodic action of the muscular apparatus of the left eye. Whenever the head was turned to the right an attempt was made to turn the eyes still further to the right without moving the head, the superior oblique and the internal rectus of the left eye contracted in tonic spasm, creating an appearance as if the eyes were fixed in the upper inner angle of the orbit. As long as the head maintained its position, the left eye failed to react to impulses of the will and in association with movements of the right eye. To overcome the spasm the patient had to turn the head toward the left to the middle line and alternately close and open the eye. The ocular apparatus was normal in all other respects. The patient presented no other evidence of disease. The manifestation was attributed to the repeated turning to the right of the head and eyes for a considerable period in the course of military exercises.—*Medical News.*

DIGITALIS IN CHOREA.

In reporting a case of chorea in which he obtained benefit from the use of digitalis and iron, Dr. Davis (*Southern Med. Record,* November, 1892) says: A desire to call attention to the benefit derived from digitalis in the treatment of chorea associated with valvular lesions, is the motive which prompted the report of the above case. That such cases are of rare occurrence, I admit, but when the conditions attending mitral insufficiency are taken into consideration, its importance as an etiological factor in chorea is at once apparent.

That anæmia is a recognized accompaniment of chorea, and in some cases the only discoverable cause, all will admit, and it is reasonable to suppose that mitral insufficiency, or rather the anæmia resulting from the diminution of oxygenated blood in the tissues, may in itself, or by intensifying pre-existing anæmia, determine an attack of chorea in one predisposed. In such cases, every effort should be made to improve *nutrition,* and in addition to other treatment, digitalis, by restoring the relation between arteries and veins, will prove very advantageous. It will effect cures when all else has failed. It should be given in *every* case of chorea associated with a heart lesion for which the drug would be ordinarily prescribed, and in these cases it is as distinctly curative in its effects as Fowler's solution.

NATIONAL SOCIETY FOR THE EMPLOYMENT OF EPILEPTICS.

We have frequently called attention to the unfortunate condition to which many epileptics, and often their friends, are reduced in consequence of their disease, and it was only recently that we alluded to the opening of Lady Meath's Home of Comfort for Epileptics at Godalming—a most laudable attempt to alleviate some of the miseries which are attendant on epilepsy and similar disorders. From a document before us we now learn that a society under the above name has been formed to provide a home for necessitous epileptics who are able and willing to work, but who are unable to obtain employment on account of their affliction. It is intended to have a series of cottages, each accommodating ten to twenty epileptics. The sexes will be separated and adults and children will be kept apart. Market gardening, spade and barrow labor, will be the first industries, and as the colony extends other trades and mechanical arts will develop. In this way it is hoped that the institution will be, to a certain extent at least, self-supporting. It will be under medical supervision and entirely undenominational, and while in the first instance intended for the poor, its advantages will also be extended to patients possessed of means, who will be received as boarders. The institution is intended to be conducted on lines similar to those on which the Bielefeld Epileptic Colony has been so successfully organized, and a beginning is to be made with a few male patients. Only money is needed to allow a fair start to be made, and this, it is hoped, will soon be forthcoming. An influential executive committee has already been formed and many have intimated their willingness to support the scheme. The honorary secretary is Miss Burden-Sanderson, Branksome, Greenhill-road, N. W., and the honorary treasurer, Mr. H. N. Hamilton Hoare, 37 Fleet-street, E. C.,London.—Editorial in *Lancet.*

JUDICIOUS BLOOD-LETTING.

In beginning an interesting article (*British Medical Journal,* November 5th) on this subject Dr. Samuel West of St. Barthomew's Hospital, says:

The indications for bleeding seem to be especially two, the one mainly mechanical and the other mainly physiological. In the one case, by the removal of

blood in sufficient quantity, mechanical relief may be given to over-distended heart or vessels, as, when there is extreme congestion in the pulmonary circulation, or when a dilated heart is failing from over-distension. In the other the bleeding is performed in order to produce rapidly the physiological effects of loss of blood with the view of controlling, and if possible checking, a hæmorrhage which is taking place elsewhere into a vital part. Hæmorrhage, unless it comes from a very large vessel, is rarely of itself fatal. Patients die after hæmorrhage but not often of it, for as soon as a sufficient amount of blood has been lost fainting occurs, the blood pressure falls, and the blood has time to clot and seal the aperture, unless the bleeding vessel be too large. Within the skull and in the lungs death from hæmorrhage is not rare, but it is due in the former case to the effect of the hæmorrhage on the brain, and in the latter to suffocation. The danger to life in both cases is not so much from the hæmorrhage, but from the place in which the hæmorrhage occurs. If then the collapse necessary to produce the fall in blood pressure could be rapidly produced by bleeding elsewhere, the further escape of blood into the dangerous parts would be prevented. Consequently in apoplexy, and even in profuse suffocative hæmoptysis, a timely bleeding might save life, but it is the timeliness that is of the essence of the treatment, and in the nature of things appropriate cases must be of rare occurrence. Bleeding for hæmoptysis must ever remain a matter of theory rather than of practice. I have never bled for hæmoptysis myself, for I have never seen what appeared to me a suitable case, but it was an old-fashioned and recognized method of treatment. Ordinary hæmoptysis, even when profuse, does not call for bleeding, and suffocative hæmoptysis, the only form in which bleeding would fulfil the indication, is too quickly fatal, and gives no time.

REMEDIES IN SCORPION STING.

Between April and June, 1892, I had an opportunity of treating forty-six cases of scorpion sting. Of this dreaded arachnid (*Scorpio afer*) there are four varieties: (*a*) A dark brown, (*b*) a reddish-brown, (*c*) one the color of prepared leather (pale yellow), and (*d*) one which is slate-blue. Of these, the first and last are the most deadly. The first mentioned has the largest sting (half an inch long) and measures altogether four inches. The last, which is also most to be dreaded, measures from mandibles to telson half an inch to an inch and a half. The larger animal is sluggish and prefers dusty and manure-like soil; the smaller is found in stony places, abounds in the hills, and can endure extremes of temperature. My patients all suffered in the same way, with of course constitutional modifications. The part stung was reddish and œdematous and the pores of the sweat glands were unusually distinct. Severe burning pain was complained of in the part and extended rapidly. In some free perspiration occurred and was followed by much excitement and delirium. Females did not suffer much, and children wept much, but without exhibiting severe local effects. Men of strong build suffered most, and in some instances were very excited; but resolute persons expressed no great suffering. In all cases the joint above the part stung was almost stiff, and in some there were febrile symptoms with severe headache. Ten of my cases were treated with ipecacuanha poultices, as text-books recommend, but only with transient benefit, as I had in addition to use chloroform stupes. This relieved all pain, but the erysipelatous swelling of the affected parts remained, and continued in severe cases for seventy-two hours, requiring still further treatment. In two cases chloroform alone was used and gave instant relief, but swelling remained in this instance likewise. In five cases hydrate of chloral pure and simple was rubbed into the part. It answered well, relieving

pain instantly, and with this remedy there was no subsequent swelling. The action of chloral was, moreover, less evanescent than that of chloroform. In order to use in a more convenient and more rapidly absorbable form it was liquefied with the addition of camphor (three parts of chloral and one of camphor), and to render its action still more rapid the part was punctured with a pin or needle before its application. Menthol-camphor, and butyl-chloral-camphor were also found efficacious. Without wishing to depreciate the value of other methods, this treatment, which I found successful in twenty severe cases, will, I trust, have a more extended trial from the profession in the tropics, in order that its value may be determined and its efficacy established.—Dr. Banergie, *Lancet.*

LIGATURE OF THE ILIAC ARTERIES THROUGH THE PERITONEUM.

In the *British Medical Journal* of October 29th Mr. Sheild asks a question in operative surgery—as to whether the time has not arrived when the old operations for ligature of the iliac arteries outside the peritoneum shouldbe abandoned in favor of an intra- or rather transperitoneal method. It is an idea which has presented itself to other minds before, and in 1889 I acted on this belief and ligatured the common iliac artery through a median laparotomy incision for a rapidly increasing aneurysm of the external iliac. The operation was performed with ease, and the patient recovered rapidly without suffering from shock, fever, or any untoward symptom. The case was mentioned in the medical journals of June 29th, 1889 (and I think on July 6th also), but I have not found time or have been negligent in publishing the details of the case. It is, I believe, the first case in which ligature of the common iliac artery by this method has proved successful, but the experience was so favorable that I cannot conceive a case in which any other method could lay claim to greater consideration. The ghastly incisions through the parietes and the laborious stripping up of the peritoneum, which I had to recommend during the ten years I taught operative surgery in the Medical School of Guy's Hospital, inspired me with distrust and filled me with disgust. For the common and internal iliac arteries I have no doubt the old extraperitoneal method will be entirely superseded in the direction I have indicated. Exception will probably be made in favor of the old method for the external iliac, which, tied by Astley Cooper's method, is a neat and effective operation within the range of a surgeon of average skill. Soluble aseptic ligatures and antiseptic wound dressings must have credit for pushing forward the surgery of arteries both in new directions and in greater safety.—Letter of Dr. Lucas in *Brit. Med. Jour.*

The canal which is to take the sewage of Chicago toward the Mississippi and relieve the lake and the water-supply from the filth which is now poured into it in large quantities, has been formally begun. This canal will take from Lake Michigan 600,000 cubic feet of water a minute, which is to be hoped will be enough to diute the sewage sufficiently to make the region tolerable through which the canal will pass. From the point at which the Chicago River leaves Lake Michigan to the Union Stock Yards is about four and a half miles, and it is at this point that the canal will leave the Chicago River and run about thirty miles to the Des Plaines River, near Joliet. It is estimated that it will take four or five years to complete the work and that the cost will be from twelve to twenty million dollars. The drainage district will comprise the city and considerable out-lying territory.—*Ex.*

Medical Items.

Bicycle riding is said to have proved curative in several cases of persistent sciatica.

The St. Petersburg hospitals are trying, for their cholera cases, colon irrigations with solutions of peroxide of hydrogen.—*Denver Medical Times.*

Dr. Waugh recommends tincture of benzoin as *par excellence* the best remedy for localized pruritus. As it is somewhat irritating it is best to dilute it before applying.—*Ex.*

A one per cent. solution of permanganate of potassium has been used successfully as an antidote for phosphorous poisoning in dogs. The phosphorus is changed into innocuous phosphoric acid.—*Denver Medical Times.*

Asbolin is a yellowish syrupy liquid recommended as a specific for many diseases, particularly tuberculosis. It is presumably an alcoholic distillate, as pyrocatechin and homopyrocatechin have been found in it.—*American Druggist.*

The International Exhibition of Hygiene, Pharmaceutics and Food will be held at the Royal Aquarium, Westminster, London, from January 15 to February 18, 1893, under the auspices of the Continental Importation Society.

The *New York Medical Journal* states that Professor Hobart A. Hare, of Philadelphia, has, at the request of the Nizam of Hyderabad, undertaken a new research on the action of chloroform.

A woman named Margaret O'Grady about two years since accidentally swallowed a needle, and last week complained of a disagreeable sensation in her shoulder. On examination at the hospital it was found that the pain was due to the needle and it was extracted without difficulty.—*Ex.*

A crystalline exudation on the skin has been observed by Drasehe (*Therapeutische Monatshefte*) after the exhibition of salophen. The crystals appeared where, after exhibiting 2 to 8 grains of salophen per day, perspiration followed.—*American Druggist.*

The congress for the study of tuberculosis announce a prize of three thousand francs for the best essay on "The Means of Diagnosticating Latent Tuberculosis Before its Appearance or After its Cure." The essay must be written in French and sent to Dr. L. H. Petit, 76 Rue de Seine, Paris, before April 1, 1893. Each memoir should be accompanied with a sealed envelope containing the author's name and address.—*Ex.*

Dr. V. H. Coffman, of this city, uses canton flannel (aseptic) in laparotomies and claims that the mortality from shock is greatly lessened. His theory is that chilling of the contents of the abdominal cavity is by this means retarded, and that one of the greatest dangers in this operation is from this lowering of temperature by such fabrics as gauze (linen or cotton), from which evaporation is so rapid. He claims that there is no danger of any *nap* remaining in the peritoneum.—*Omaha Clinic.*

Alumnol is the name given by Dr. R. Heinz, of Breslau, to a new preparation which is stated to be the aluminum salt of an aromatic sulfonic acid; according to the *Pharmaceutische Centralhalt*, probably oxymethyl-sulfonic acid. It is easily soluble, non-hygroscopic, antiseptic and astringent, and, unlike the salts of

the heavy metals, penetrates the tissues. It is recommended in gonorrhœa in one to two per cent. solution, in suppurating wounds, skin diseases, etc.—*Ex.*

Seeing the election resulted in a victory for the party advocating tariff-reform, we wait with some anxiety the removal of the tariff from microscopes, surgical and medical instruments and scientific books. If these are put on the free list physicians will receive much benefit.—*Cincinnati Lancet-Clinic.*

Maine druggists have prepared a bill to be presented to the next legislature which will allow them to sell liquors for certain purposes and under proper restrictions. It proposes to place the power of selecting who shall sell in the hands of the judges of the Supreme Court, and they also shall have the power to revoke all such licenses whenever it may appear that any person has abused the privilege granted him.

The death of Dr. John James Reese, of Philadelphia, on the 4th of October, removed the veteran toxicologist of the University of Pennsylvania. He resigned in October, 1891, the professorate in medical jurisprudence held by him since 1865, and became professor emeritus. He was the author of a Manual of Toxicology, and edited the seventh edition of Taylor's Medical Jurisprudence. He was physician to St. Joseph's Hospital and other institutions. He was in his seventy-fifth year at the time of his death, which took place at Atlantic City.—*Ex.*

A decidedly practical turn has been given to urban sanitation by the action of a number of public spirited and thoughtful women of the city of Brooklyn, N. Y., who have banded themselves together under the name of "Neighborhood Societies." The function of these associations is to improve the sanitary conditions of their immediate sections by having the vacant lots, alleys, backyards and front-yards kept in an attractive manner, while at the same time they look after the sanitary condition of the houses of the poor, have the fences repaired, the garbage burned or carted off, and formal reports are made at the regular meetings at private houses of the members as to the results attained in this commendable work. It is to be hoped that this work will rapidly become popular among the better classes, as it will be of incalculable benefit in arresting and preventing the spread of disease.—*Ex.*

Acute infectious epiphysitis is due to the irritation and suppuration occasioned by the entrance and development of the staphylococcus of pyogenes aureus and it is a specific disease and not merely traumatic periostitis which gives rise to death of the shaft. 2. The earliest symptoms appear in the juxta-epiphysial regions and spread thence inwards to the periosteum, assifted by the continuity of the latter with the epiphysial cartilage. To prove this point I made a series of experiments on young rabbits, and in the article in question full details are given. 3. In casas of total death of the diaphysis the destructive process is most marked at the extremities, the bone here being found eroded and gangrenous; and further, there is such a loss that the dead shaft no longer fits accurately into the epiphysial and periosteal cap.

You also remark that amputation seems to be the only treatment. With this I cannot agree, as the conclusion I came to was that operators must not merely be content with incising the periosteum and letting out the pus, but should attack the disease immediately at its root by tunnelling the juxta-epiphysial junction in addition, and so allow a sufficient exit for the products of the inflamed medulla.—Dr. Tubby, *Lancet.*

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CROUPOUS RHINITIS, WITH REPORT OF THREE CASES.

BY J. W. LONG, M. D., RANDLEMAN, N. C.,

Member of the Southern Surgical and Gynæcological Society; North Carolina State Medical Society; Secretary of the Randolph County Medical Society; etc.

Before entering into a discussion of croupous rhinitis proper, it will perhaps be well to consider briefly the various kinds of inflammation to which the mucous membranes of the upper air-passages are liable. We will notice three kinds, as follows:

1. Catarrhal inflammation.
2. Croupous inflammation.
3. Diphtheritic inflammation.

1. *Catarrhal* inflammation is the form most frequently seen. In the milder cases it is characterized by merely an increased secretion of mucus. There is an increased flow of blood to the parts, which stimulates the cell elements to abnormal activity; new cells are generated; liquor sanguinis transudes from the blood-vessels, the glands pour out excessive quantities of mucus, the result being a greatly increased flow of mucus which is charged with young epithelial cells, or mucus corpuscles, and emigrant blood corpuscles. The membrane is at the same time reddened and thickened as a result of the increased blood-supply. If the irritation be severe, the vascular phenomena are more pronounced, and cell genera-

tion more rapid. The cells fail to mature and are poured forth in an unripe state, and can be distinguished from pus corpuscles only by their larger size and rather more regular outline. The discharge finally becomes purulent from containing such an abundance of these mucus and pus corpuscles. The epithelium becomes loose and falls off in places, leaving abrasions. The process continuing, the sub-epithelial layer, or mucous membrane proper, becomes involved. The cell-elements in this tissue are generated more rapidly, distending and infiltrating the parts, causing the membrane to become more thickened and swollen. This acute process may be relieved, or pass into a chronic state. These are, in brief, the phenomena observed in an ordinary catarrhal process of a mucus membrane.

2. *Croupous* inflammation is of a higher grade and more intense form than the catarrhal. The process begins in the same way—with increased blood supply, escape of liquor sanguinis and blood corpuscles, and rapid cell proliferation; but is distinguished from catarrhal inflammation by the transuded liquor sanguinis containing a large amount of albumen and fibrin, which coagulates upon the surface of the mucous membrane, forming a *false membrane.* This pseudo-membrane is more or less dense in character; sometimes it is soft and friable and easily removed with a soft brush, while at other times it is so dense as to be hard to tear even after removal. This membrane consists of a basement membrane of fibrillæ of fibrin, enclosing in its meshes granular fibrin, epithelial cells, and white blood-cells. The distinctive feature of this false membrane is that it is *upon the surface* and *does not penetrate the substance of the mucous membrane.* Why this membrane forms is not thoroughly understood. It is supposed to be due to a previously existing state of the blood, which dominates the inflammatory process, and so enriches the exuded liquor sanguinis with fibrinous material that it coagulates on exposure to air, and thus forms a false membrane, which takes the place of the ordinary fluid discharge. This view, that croupous inflammation depends on some previous condition of the blood, is borne out by the fact that the onset and course of the disease are usually marked by a higher grade of fever than is ordinarily seen in catarrhal inflammation, the temperature in simple membranous sore throat often reaching 103° and 104°. This form of inflammation may occur in any mucous membrane, but its favorite site is in the upper air-passages; and it may occur as a croupous tonsillitis, croupous pharyngitis, croupous laryngitis, croupous rhinitis; or the exudation may take place in the follicles of the membrane as in acute follicular tonsillitis, which is really a croupous tonsillitis, the exudation taking place in the follicles instead of on the surface of the tonsil.

3. *Diphtheritic* inflammation also begins like the catarrhal—with its increased blood supply, exudation of liquor sanguinis, and rapid cell proliferation, and, like croupous inflammation, the exuded liquor sanguinis is rich in fibrin and albumin; but there is this difference: while in *croupous* inflammation the exudate is poured out *on the surface* of the mucous membrane, in *diphtheritic* inflammation the exudate *permeates and infiltrates the entire thickness of the mucus membrane down to*

the sub-mucous layer. This exudate permeates the membrane so thoroughly that in undergoing coagulation it destroys the vitality of the mucous membrane, producing a dead membrane. This is called "coagulation necrosis." The false membrane here described appears to the eye as a *dead membrane, necrosed and sloughing,* of a *dark grayish color,* resembling *boiled maccaroni;* while a croupous membrane presents a *bluish, pearl-gray color,* with *no appearance of necrosis,* but rather of *living tissue.*

In this section (middle North Carolina) catarrhal inflammation of the upper air-passages is much more common than the other two forms of inflammation combined. Next, in point of frequency, comes the croupous variety, which is exceedingly common throughout this whole country, appearing in a variety of forms; sometimes as acute follicular tonsillitis; sometimes the membrane covers an entire tonsil, constituting croupous tonsillitis; again, it occasionally occurs in the larynx, when it is called croupous laryngitis, or "true croup"; and less frequently it develops in the nose and is then known as *croupous rhinitis.* So common are the first two varieties mentioned, that I suppose every doctor in this section sees from dozens to scores of them every year. The last two varieties are rarely seen, particularly croupous rhinitis. But the point to be borne in mind is, that *all croupous inflammations of the upper air-passages are essentially of the same nature;* and any difference of symptoms which the various forms may produce is purely adventitious, and depends not upon the nature of the disease but upon the location of the membrane; as, *e. g.,* when on the tonsil, the symptoms are by no means alarming; when in the nose, there is complete nasal obstruction; and when in the larynx, there is imminent danger of suffocation from the mechanical obstruction.

I might add in this connection that diphtheritic inflammation is not at all frequent here. I do not average seeing one case a year.

At long intervals an epidemic of diphtheria sweeps through the country, and occasionally we see sporadic cases of genuine diphtheritic inflammation.

These remarks will give us, it is hoped, not only a clear idea of the inflammations of the upper air-passages, but some idea of the relation which croupous inflammation bears to the other varieties.

We can now readily understand that croupous rhinitis is an acute inflammation of the nasal mucous membrane, characterized by the formation of a false membrane on the surface of the mucous membrane.

The first mention of this disease in medical literature is by Schuler, in 1871, who reports the case of a five weeks old infant whose nose was stopped with pseudo-membrane, which the author called diphtheritic. Frankel refers to this condition as a complication of diphtheria of the nose.

Cohen certainly recognized this disease as distinct from diphtheria, but with this exception most writers previous to 1887 confounded the two affections. In this year (1887) Moldenhauer gives an accurate description of its course and symptoms; while Hartmann reports six cases.

In the same year, cases were reported by Seifert and Ryderson. Bresgen reported cases in 1888, Potter and Baumgarten in 1889, Chapin in 1890, and Newcomb in 1891. Bosworth devotes a most excellent chapter to this affection in his recent work on "Diseases of the Nose and Throat." Dorin ("Archives of Pediatrics," February, 1891, p. 115) gives a comprehensive syllabus of this disease, clearly differentiating it from diphtheria of the nose. Drs. Sajous and Whitherstine, in the last edition of Sajous' Annual, devote a section to "Croupous or Fibrinous Nasal Diphtheria," and evidently confound the two diseases; although they notice that Chapin and Baumgarten make a clear distinction, the latter claiming priority over Hartmann in describing croupous rhinitis.

This reference to the literature of the subject is sufficient proof of the rarity of the disease. Potter, in 1889, claimed that two per cent. of his cases of acute rhinitis were croupous, but later (a while before his much-lamented death) he stated that this estimate was too high, and that a larger experience had convinced him that *croupous rhinitis was a very rare disease.* This is the statement of every one who has written on the subject. My own experience in ten years' practice is limited to *three* cases, all of which occurred within a year; two of them in one group of croupous cases, the third in another like group. That we may clearly keep in mind the relation which these cases bear to each other, it will be necessary to briefly report them in the order in which they occurred.

FIRST GROUP.

CASE I.—*Croupous tonsillitis.* Floyd W., age eight years, was taken rather suddenly, November 15th, 1890, with fever and sore throat. My colleague, Dr. Woollen, was called and found both tonsils covered with false membrane; temperature 103°, pulse frequent, tongue coated, and bowels constipated. The Dr. very properly isolated his patient from the other children. The constitutional symptoms rapidly subsided and the membrane had entirely disappeared by the end of four days. There were no nose symptoms in this case.

CASE II.—*Croupous tonsillitis.* Pauline, age four years, sister of Floyd, complained, December 1st, 1890, with sore throat. I saw her the same day, and discovered a well-defined membrane covering the convexity of the left tonsil, and a small patch similarly situated on the right tonsil. I saw this case only once, the symptoms subsided so rapidly. These two cases are typical membranous sore throat cases as we see them in this country.

CASE III.—*Croupous rhinitis.* December 2nd, 1890, Annie, age six years, and sister of the above, was taken as the others, rather suddenly, with fever, but did not complain of her throat, seeming rather to have a very bad cold in her head. That night it was noticed she could not breathe through the nose. She tossed about constantly in her efforts to get breath, having to breathe through her mouth altogether. The febrile movement continued for several days, gradually subsiding; but the nasal symptoms increased instead of abating, causing her to be very restless at night, which was the occasion of my being called. I saw her on December 7th, being the sixth day of the attack. I found her tempera-

ture normal, pulse 100, tongue coated, bowels constipated, and skin sallow. She complained of feeling sick at the stomach, having vomited once. She also complained of being *unable to breathe through her nose.* The upper lip was excoriated from the nasal discharge, which was muco-purulent and abundant. The right nostril was completely occluded with a false membrane of a pearly-gray color. The membrane covered the face of the middle and lower turbinated bones and the septum, coming down in front to the muco-cutaneous junction. The left nostril was entirely covered, but not quite so stopped up, as a little air could be forced through. The throat was slightly inflamed and the tonsils a little swollen, but no sign of a membrane or deposit was visible anywhere in the pharynx. The bowels were opened with calomel; the upper lip and the nose were washed frequently with warm water and soap, to which bicarbonate of soda was added. The nose was sprayed every two hours with the following solution:

℞.—Cocaine hydrochlorate . . grs. v,
Boric acid . . . . grs. xx,
Chlorate potassium . . grs. xxx,
Glycerine . . . . ʒ iv,
M. Water, q. s. . . . . ℥ ii.

She was also given:

℞.—Corrosive sublimate . . . gr. ss,
Muriate tinct. iron . . . ʒi,
Chlorate potassium . . . ʒss,
Glycerine . . . . ʒiv,
Water, q. s. . . . . ʒii.

M. Sig.—Teaspoonful every two hours.

In addition to this I applied an eight per cent. solution of cocaine to the nose, which, however, *failed to contract the mucous membrane;* but it anæsthetized the parts to a certain degree. With a small hard-rubber probe wrapped with cotton I now tried to detach the false membrane; this was easily done at the front part of the nose. The movements of the child caused the probe to produce a little hæmorrhage, but when the false membrane was lifted it disclosed an apparently normal mucous membrane without any bleeding points. I could not easily remove the cast of membrane from the nose because it was still adherent throughout the middle and back part of the nostril and the child was very unruly. When I saw her the next day, however, the loosened front part of the membrane had come away and there was no sign of its renewal. The membrane in the middle and back part of the nose did not all disappear until the *close of the fourth week.* I made two applications of pure tincture of iron to the nose, after applying cocaine, but the child resisted so much I concluded to depend on the spray.

About the fourteenth day of the attack there appeared a very thin film of membrane on the tonsils, confined principally to the lacunæ. It was so slight, indeed, that it probably would not have been noticed but for the fact that we had the throat under daily inspection. At this time, by making the child gag, the

false membrane could be seen covering the vault and upper lateral walls of the pharynx. After the first few days there were absolutely no constitutional symptoms and the child remained in bed scarcely an hour. By the end of the fourth week the membrane had entirely disappeared, leaving a mild naso-pharyngeal catarrh and the patient somewhat anæmic.

CASE IV.—*Croupous rhinitis.* Pauline, same as Case II, December 20th; did not rest well at night; could not get her breath through the nose. I saw her in the evening, found the left nostril occluded with false membrane. The continuous membrane did not come down to the muco-cutaneous junction, but between its margin and the junction were islets of membrane. The right nostril, while not completely stopped, showed a thin film of membrane, with the islets in front. The throat showed no membrane and only a few lacunæ specks. There were no constitutional symptoms. The membrane in this case disappeared after about two weeks, leaving, as in the other case, a mild catarrh.

CASE V.—*Croupous tonsillitis.* Mrs. W., age about twenty-five years, and a neighbor, who saw these children a few times during their sickness, was taken, December 12th, with fever and throat symptoms. Inspection showed the convexity of the left tonsil covered with a pseudo-membrane. The right tonsil was clean. This membrane persisted for four or five days, the patient being quite sick in the meantime, but recovering without complications.

SECOND GROUP.

This group comprises six croupous cases, all occurring near the same time and place, one in my own family, three in a neighbor's family just across the street, and two in children who had been with my boy. I do not mention these facts in the effort to establish the *contagiousness* of croupous affections of the upper air-passages, but simply that we may have a clear idea of the relation these cases bear to each other.

CASE VI.—*Croupous tonsillitis.* Bettie F., age eight years, living just across the street from my house, was taken August 4th, 1891, with fever and sore throat. I saw her the next day, and found the left tonsil enlarged, and the convexity covered with pseudo-membrane. The right tonsil was clean. Her temperature was 103° in the P. M.

The glands moderately enlarged. The constitutional symptoms subsided after three or four days, but the membrane persisted ten or twelve days, being renewed once after having nearly disappeared.

CASE VII.—*Croupous rhinitis.* Nannie F., age three years, sister to Bettie, was noticed to be stopped up in the nose as if from cold, on the night of September 2nd, 1891. I saw her the next day. I found that she had a watery discharge from the nose, and the nasal mucous membrane swollen; but I discovered no false membrane. She had mild constitutional symptoms. I saw her again four days later and found *both nostrils completely occluded with false membrane.* The upper lip was excoriated by the muco-purulent discharge which constantly oozed from the nostrils. The membrane extended clear through the nose and

could be seen covering the vault of the pharynx, but did not extend to the tonsils. The constitutional symptoms had by this time all subsided except it be a lack of appetite and a mild degree of anæmia. Calomel was given in frequent small doses, $\frac{1}{10}$ gr., tablet triturate every two hours. Iron was also given in the following combination:

℞.—Muriate tincture of iron . . ʒ ii,
Glycerine, q. s. . . . ʒ ii.
M. S. Teaspoonful every two hours.

We at first attempted to spray her nostrils, but the child resisted so much that little good was done. We then *forcibly* syringed out the nose, using a Peerless syringe, and the following solution:

℞.—Corrosive sublimate . . . gr. iii,
Sodium chloride . . . ʒ i,
Sodium biborate . . . ʒ ii,
Glycerine . . . . ʒ ii,
M. Water, q. s. . . pint ii.

This cleaned out the nostrils quickly and thoroughly, so that in *five days* from this time the membrane had entirely disappeared. There was only slight glandular involvement in this case.

Case VIII.—*Croupous tonsillitis and laryngitis.* September 9th, my little boy, Wyeth, spent the morning riding with me, when I noticed he was slightly hoarse. Inspection of the throat discovered a membrane covering each tonsil. His temperature proved to be 101°, and the glands at the angle of the jaw were moderately enlarged. This boy was just convalescing from what was probably a mild attack of typhoid fever. I put the little fellow immediately to bed and gave him within twenty-four hours $\frac{3}{4}$ of a grain of corrosive sublimate. This was on Wednesday; by Friday the membrane seemed loosening and disappearing; his general morale better, appetite ravenous, and everything bid fair for a rapid recovery; however, he was not allowed to sit up, except in bed.

Saturday. Very much better, the hoarseness having nearly subsided, and the boy cheerful and had a keen appetite. But we still keep him in bed.

Sunday. Boy still better, but towards night the hoarseness returned, and he breathed slightly stridulous all that night.

Monday. Ate some breakfast, but the stridor increased to such an alarming degree that Dr. Woollen was asked to see the case. We gave him calomel tablet triturates $\frac{1}{10}$gr. every three hours, and began the bichloride again, but his stomach became irritable and he could not take the bichloride.

Tuesday. Patches of ragged membrane could be seen covering tonsils. Hoarseness, aphonia, stridulous cough and breathing, restlessness, and dyspnœa were all present to a mild degree. We began the use of turpentine vapor by means of a kettle of boiling water to which turpentine had been added. The vapor was conveyed to the middle of the room by means of a long tin pipe. At times a blanket was thrown over the top of the bedstead, forming a tent, and the end of the tube

introduced under the edge of the blanket, by which means we could easily give him a thorough steaming with the turpentine vapor. On this day Dr. R. L. Payne, Jr., of Lexington, was asked to see the case with us. He endorsed the calomel and advised tracheotomy in case the symptoms became more urgent.

Wednesday. Patient evidently somewhat better, the symptoms all being lighter.

Thursday. Not so well. Croup symptoms more pronounced.

Friday. Patient worse. On this day false membrane was seen on the concavity of the epiglottis. Dr. W. P. Beall, of Greensboro, was asked to join the consultation. He advised to continue the calomel at lengthened intervals and to intubate if the symptoms became more urgent. An O'Dwyer's set was kept in the room with the tubes ready threaded. The turpentine vapor was kept going day and night while the patient was given an occasional steam bath. There was such evident lack of secretion all along the respiratory track that Dr. Beall advised pilocarpine; accordingly we gave $\frac{1}{8}$ of a grain of muriate pilocarpine, which in a short while caused a copious flow of mucus into the bronchial tubes, and came near "swamping" the little fellow, but it made him vomit, and gave great relief from the stridor and dyspnœa, for the time being, and was, I believe, of genuine service. After a few hours, however, the stridor and dyspnœa returned and with marked recessions. We put him in the steam bath, which gave only partial relief, and while considering the propriety of intubating, it occurred to me that nitroglycerine relaxes arterial tension, and everything about this little fellow was on a high degree of tension. So we gave him gt. $\frac{1}{3}$ of the one per cent. solution. In fifteen minutes he was breathing easier and with less stridor and dyspnœa. The dose was repeated three or four times with marked improvement after each dose. From this time his recovery was uninterrupted, except that the attack was followed by an acute nasal catarrh.

Case IX.—*Croupous tonsillitis.* Maud, age eleven years, sister to Bettie and Nannie, complained on Thursday night, September 17th, of her throat. Her mother saw a speck on the left tonsil. Patient rested well that night; but had a chill Friday morning. I saw her in the afternoon. Temperature 104°, a croupous membrane covered the entire left tonsil, fauces, and posterior surface of the soft palate to the edge of uvula. Right tonsil clean. Glands slightly swollen. Vigorous use of an alkaline spray and a probe, wrapped with cotton, enabled us to remove the membrane.

Saturday. Nose bled; and expectorated some blood. The membrane was reformed during the night and was nearly all removed with the spray. Temperature in the P. M., 102.5°. Next day there was scarcely a rise of temperature; and none at all for the two next days.

Wednesday there was only a very little of the membrane present, and the patient was up. On this day she complained of the right side of the throat. Her mother saw streaks of membrane on the right tonsil, and the child had high fever again.

Thursday. Temperature 103¼°, pulse 120. Glands at angle of right jaw greatly enlarged. Left tonsil clean and reduced to normal size. Right tonsil enlarged and covered with membrane of a dark pearl-gray color, except at its anterior edge; the membrane extended well to the uvula. Spray changed to peroxide of hydrogen.

Friday, A. M. Temperature 100½°. After vigorous spraying, removed the entire membrane with a cotton-wrapped probe.

Saturday the membrane had reformed, but was thinner. After a few days it entirely disappeared.

Case X.—*Croupous tonsillitis.* Epsie, age five years, daughter of Dr. Woollen, was feverish on the night of September 16th-17th, A. M.; temperature 103°; complained of her throat. On the 18th, temperature 103°, and right tonsil covered with membrane. On the 19th, membrane disappearing from right tonsil, but half of left tonsil covered; temperature 101°. After two days the membrane had all disappeared. There was only moderate glandular enlargement in this case. This child had played freely with my boy (Case VIII), before he was taken sick, but did not see him afterwards; nor did she see Cases VI, VII and IX after the first one was taken, on August 4th.

Case XI.—*Croupous tonsillitis.* Nettie F., age 18 years, called to see my boy while he was still in bed, but after the membrane had all disappeared. September 24th, was restless at night, September 27th, 4 A. M., had a chill. I saw her at 9 A. M., found temperature 103°, which continued till night, falling to 100½° after taking aconite and antipyrine. She complained of aching all over. The right tonsil was enlarged, reddened, streaked with membrane, and the mouths of the lacunæ full of croupous deposit. Glands only slightly enlarged. Temperature on 27th was 100°, and membrane disappearing. By next day tonsil clean and patient sitting up.

Of course the important question to decide is whether these cases were *croupous* or *diphtheritic.* It has been the habit in this country to call all cases of membranous sore throat *"diphtheria"*; and as nearly all of them get well some doctors have attained great celebrity for curing nearly all their cases of diphtheria. It surrounds a case with so much more importance to call it "diphtheria" than to say candidly to the family, "This is a case of simple membranous sore throat and will probably be well in a few days."

While some of the older works on diseases of children contain a few references to croupous inflammation of the throat, all croupous inflammations are generally regarded as diphtheritic. In 1881 Bosworth† gave a clear description of croupous tonsillitis, defining it as a distinct form of inflammation from diphtheria. Since then numerous writers have differentiated the two affections. Now, it has already been stated that croupous rhinitis is identically the same in nature as croupous membrane on the tonsil or elsewhere. Of course the same is true of diphtheria.

†Diseases of Throat and Nose.

Dorland‡ makes the clearest cut distinction between the two affections when occurring in the nose that I have seen:

Croupous rhinitis.	Diphtheritic rhinitis.
1. Rarely attacks adults.	1. Frequently attacks adults.
2. Of sthenic type.	2. Of adynamic type.
3. Febrile action marked.	3. Fever usually slight.
4. Pulse usually strong and hard.	4. Pulse weak, rapid and full.
5. Constitutional involvement slight.	5. Constitutional involvement profound.
6. Slight enlargement of glands at angle of jaw.	6. Great enlargement of glands at angle of jaw.
7. Nasal discharge odorless and containing fragments of false membrane.	7. Nasal discharge of a sweetish, unpleasant odor, and never containing fragments of false membrane.
8. Membranous formation clean, of a whitish color, soft, friable, non-adherent, leaving mucous membrane beneath intact.	8. Membranous formation dirty, of ashy or gray color, tough, dense, adherent, leaving the membrane beneath torn and bleeding.
9. False membrane removed in small granular masses, and shows no evidence of necrotic processes.	9. False membrane removed in one continuous piece, and shows marked evidences of necrosis.
10. Membranous deposit upon the eye-lids easily removed.	10. Membranous deposit upon the eye-lids not easily removed.
11. Complications and sequelæ slight.	11. Complications and sequelæ severe.
12. Never followed by paralysis.	12. Often followed by paralysis.
13. Rarely fatal.	13. Frequently fatal.

I have never seen a case of nasal diphtheria, other than those cases complicating diphtheria of the throat; but from my personal experience with croupous inflammations, and particularly croupous rhinitis, I am ready to believe this to be a "true bill."

The three cases I have seen verify every point he gives except No. 10, relating to membranous deposits on the eye-lids; this I have never seen. Especially should the *sudden onset* of croupous rhinitis, with high fever, frequent, full-bounding pulse and speedy formation of membrane, be contrasted with the *insidious approach* of diphtheria, with its low temperature, weak, rapid pulse, tardy formation of membrane, and adynamic type generally. Again, in the former the *constitutional symptoms rapidly subside;* while in the latter they *steadily increase.* Another point worth emphasizing is that in croupous rhinitis the false membrane is of a *whitish, pearl-gray color,* and, being *on* the mucous membrane, is *easily removed;* while diphtheritic membrane is a *dirty-gray color, necrotic*—indeed, a genuine *slough, involving the whole thickness of the mucous membrane*—and *can not be*

‡Archives of Pædiatrics, February, 1891, page 117.

removed without causing hæmorrhage. It may also be noticed that diphtheria of the nose is one of the most fatal diseases known, while croupous rhinitis is rarely, if ever, fatal. The latter affection is rarely accompanied by sepsis, and this is significant when we remember the rich lymphatic system which surrounds the nose. Chapin§, quoting Simond, says they are especially abundant in three places—(1) at the top of the superior turbinated bone; (2) on the external surface of the middle turbinated; (3) in the space in front of this.

The fact that *cocaine does not contract* a mucous membrane, the subject of croupous inflammation, is regarded as a diagnostic point. Not only is this true, but I have noticed that in these cases cocaine has *very little anæsthetic effect.* We might suppose that a search for the Klebs-Löffler bacillus would settle the diagnosis between croupous and diphtheritic inflammation; but since it has been shown that there are *two* kinds of diphtheria, one in which the bacillus is present and another in which it is absent, we can not rely on this point; for while its presence would prove diphtheria, its absence would prove nothing.

Most authors consider the following varieties of croupous rhinitis:

1. Idiopathic (very rare). Tendency of membrane to spread.
2. Traumatic (common). No tendency of membrane to spread.
   (1) From use of galvanic-cautery (*Bresgen*).
   (2) From insufflation of impure water (*Hering and Smithison.*)
   (3) Following operations upon nose.

Of course this paper relates more particularly to the idiopathic form.

The cause of this disease is thought to be (1) excess of fibrin in the blood, (2) deposit of specific germ on nasal muceus membrane. What this specific germ is no one has attempted to say, but it is believed to act very much like the Klebs-Löffler bacillus, the specific germ of diphtheria. The germ is lodged on the nasal mucous membrane and sets up a specific inflammation; at the same time either the germ or most probably its *ptomaines* are taken up by the circulation and produce the systemic disturbance; in other words, the croupous membrane is only the local manifestation of a systemic disease.

Another interesting point to consider is whether or not croupous rhinitis is *contagious.* It is generally considered to be *non*-contagious (Dorland); but I believe *all croupous affections* to be more or less contagious; and always urge isolation of the patient. That croupous cases (of which we have seen that croupous rhinitis is but a type) do not *always infect other persons* when not isolated, is no argument against their contagiousness; for while diphtheria is well known to be one of the most contagious diseases we have, I have seen an undoubted case of diphtheria-membrane in the fauces, in the larynx, in the nose to its very tip, gums bleeding, sepsis, death—with the room constantly crowded with children and yet not a single one of them contracted diphtheria. I go farther, and say the germ of croupous inflammation may be carried by a non-infected person and infect a third person. A recent experience seems to sustain this. Dr. Woollen and I attended a difficult labor—primipara, eclampsia, forceps and lacerated perineum

§New York Medical Journal, June 21, 1890, p. 687.

—which was repaired at once. This was followed by mild sepsis, with difficulty in passing water. While attending this woman, I stopped on the way to examine a case of croupous tonsillitis. I then drew the lying-in woman's water without first washing my hands. That this is reprehensible has nothing to do with the case. The next day, the whole vagina and torn surfaces were *covered with croupous membrane,* necessitating cutting the stitches and active local treatment. The membrane disappeared in two days and the woman recovered.

In the way of treatment, Bosworth's suggestions are perhaps the best. Calomel in frequent small doses; mur. tincture of iron in glycerine every four hours; and locally, removal of the membrane by means of a probe wrapped with cotton; then painting the mucous membrane with pure tincture of iron, or officinal solution of persulphate of iron. Also the spray with an alkaline antiseptic solution and frequent applications of cocaine to the parts to control the blood supply and nasal stenosis.

To this treatment I should like to add the use of a solution like that for spray, to be *forced through the nose* several times a day by means of a *Peerless syringe.* The immediate good results in Case VII justifies an approval of this method, which I have not heretofore seen mentioned.

I am largely indebted to Dr. Bosworth's recent work‖ for the description given of the various forms of inflammation; I have also referred freely to Dr. Chapin's and Dr. Dorland's articles.

A CASE OF OVARIAN PREGNANCY; LAPAROTOMY; CURE.

BY EMORY LANPHEAR, M. D., PH. D.,
Surgeon to All Saints Hospital, Kansas City, Mo.

Mrs. John W., age 42 years, patient of Dr. T. Brown, of Hamilton, Mo., two children—one 18 years and one 14 years of age; pregnant four years ago, but miscarried at four months; never well since; menstruating too freely and suffering from retroversion. Last menstruation occurred the last of May, 1892; some symptoms of pregnancy. August 2nd, was taken with hæmorrhage from the uterus, accompanied by excruciating pains in left ovarian region, the bleeding stopped, but pain continued, with great collapse, and the abdomen became distended to its limit. Temperature has ranged from 99½ to 102. In the night of August 15th I first saw her and examined her under chloroform. The whole pelvis was filled with a boggy mass, the lower part of abdomen very full and a lump the size of a large orange easily made out in the left ovarian region. I therefore felt convinced of the accuracy of Dr. Brown's diagnosis of ruptured tubal pregnancy, and advised operation. On the morning of August 16th, assisted by Drs. T. Brown and W. T. Lindley, I made abdominal section, and removed about one and a half gallons of fluid and of clotted blood; the left ovary was found to be the seat of the pregnancy, its tube being whole and unaffected save that the fimbriated extremity was bound down to the broad ligament by inflammatory action; to the ovary the placental attachment was plainly made out, and

‖Diseases of Throat and Nose.

in its ruptured envelop the dead fœtus. A clamp was applied, and the broad ligament transfixed and tied with catgut, the tube, remnants of ovary and the baby cut away. The abdomen was then thoroughly irrigated with boiled hot water to the amount of about eight gallons, and the abdomen closed with catgut sutures, without drainage, with the usual dressings. Six hours later the temperature had dropped two degrees and the patent was free from pain for the first time in many days; but little shock. August 20th, she was reported as free from pain, sleeping well and appetite returning; temperature normal and pulse 80. Recovery was uneventful, she being allowed to sit up in bed on the tenth day and to walk a little by the sixteenth.

Examination of the specimen showed conclusively that this was a true ovarian pregnancy, the tube being as perfect as any I have ever seen, save at its extremity, as already mentioned.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD NOVEMBER 4, 1892.

The 270th regular meeting was called to order by the President, Dr. William E. Moseley.

Doctors Berwick Lanier, Stephen Crowe and H. B. Stevenson, all of Baltimore, were elected to membership.

The program for the evening was a discussion on "Cholera." (See page 89.)

Doctors Osler and Chew, who were to have considered the clinical features of the disease, were both unavoidably absent.

Dr. Thomas S. Latimer gave, in a very thorough manner, an account of the "Geographical Distribution of Cholera."

Dr. I. E. Atkinson spoke upon the "Therapeutics of Cholera" as follows:

Dr. William Welch spoke upon the "Etiology of Cholera and the Bearing of the Discovery of the Bacillus and its Properties upon the Cause and Spread of the Disease."

Health Commissioner McShane, of Baltimore, then gave an interesting account of the work done by the department, of which he is chief, to improve the sanitary condition of Baltimore and to prevent the entrance of cholera into the city.

When asked if he had any authority to abate the nuisances detected along the tributaries to Lake Roland, he replied that as an ex-officio member of the State Board of Health he assumed such authority. Unless some plan of filtering Lake Roland water is adopted, Dr. McShane fears that the Lake as a source of water supply for Baltimore will have to be abandoned.

1519 N. Broadway. W. T. Watson, M. D., Secretary.

A writer in the *Journal of Orificial Surgery* recommends dilatation of the sphincter ani as a cure for cold hands and feet. The physician must now carry a rectal dilator with him on his rounds if he would meet the needs of family practice.

THE MARYLAND MEDICAL JOURNAL.

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BALTIMORE, DECEMBER 3, 1892.

Editorial.

THE PROFESSION OF THE "EASTERN SHORE."

We may be called presumptuous if we venture, after a single day's intercourse with the physicians of the Eastern Shore of Maryland who assembled at Easton and greeted the Medical and Chirurgical Faculty at its semi-annual meeting, to give expression to some reflections concerning the status of the profession in that garden spot of the State; yet the utterance of friendly criticism at an opportune moment is always to be welcomed, if only as an occasion of free discussion of subjects which demand more attention than has been given to them.

On the whole Eastern Shore (exclusive of Cecil) in the eight counties of Kent, Queen Anne's, Caroline, Talbot, Dorchester, Wicomico, Somerset and Worcester, which possess many of the oldest, most cultured and most influential families of the State: which boast four thriving towns of between two and four thousand inhabitants; and which are well supplied with intelligent practitioners; we find, with all these advantages, but two county medical societies, and these not devoted to medical discussions. In extenuation of this apparent lack of harmonious action, it may be urged that the eastern coast of the Chesapeake is broken into long peninsulas, between which communication, except by boat, is very difficult and roundabout, so that evening meetings are very inconvenient. But with the extension of railroads there can be no excuse for future lack of medical intercourse.

The two county medical societies above referred to are those of Talbot and Wicomico. The Talbot County society has recently, we understand, lost its hold upon the interest of its members, because of discussions relating to medical fees. We would be glad to receive from some subscriber, who is a member of it, an account of its foundation and work.

The Medical Society of Wicomico County was organized three or four months ago, with about twenty members. Dr. S. P. Dennis is President; Dr. F. M.

Slemons, Vice-President; Dr. George W. Todd (?), Secretary; Dr. L. W. Morris, Treasurer; all of Salisbury. Other members are: Drs. John S. Fulton and E. W. Humphreys, of Salisbury; J. A. Wright, of Delmar; Lee Warren, of Fruitland; G. W. Truitt, of Parsonsbury; Louis Wilson and W. C. Marstens, of Barren Creek; W. H. H. Dashiell, of Quantico; Wm. Catlin, Tyaskin; J. I. T. Long, of Allen; G. W. Freeney and James Littleton, of Pittsville; and Lemuel Mitchell, of Sharptown. Four meetings have been held in Salisbury for organization, but no papers have been read so far. It is proposed to hold the meetings in future at suitable points in the country along the line of the Eastern Shore Railroad. A plan is on foot to affiliate with the Talbot County Medical Society. We hope that literary work will soon be taken up.

We find fault with the profession of the Eastern Shore in that it shows a tendency to look to Philadelphia as its centre instead of Baltimore. We would remind our friends that "Maryland" should be their watchword and that Baltimore should be the Mecca of their devotions. It is certainly unnatural for the profession of a great section of our State, which should aid in the advancement of her medical interests, to own allegiance to another State. Baltimore is now fitting herself to meet all the demands of a great medical centre, and it is time that all the medical interests of Maryland should look to her for leadership. We hope that the county societies of the Eastern Shore will encourage intercourse with Baltimore physicians. An occasional excursion to a session of one of the county societies would be welcomed by many of our city physicians as a holiday trip, and would be a source of both pleasure and improvement to both parties.

We would also remind our county friends that they will be very welcome, both at the April meeting of the Faculty and at the bi-weekly sessions of the city medical societies.

OUR WEEKLY CHRONICLE.

The City Health Officer calls attention in the daily press to the necessity for more extensive vaccination in the city, as a number of cases of small-pox have been recently reported. The residences of the city vaccine physicians for each ward are as follows: 1st, W. H. Schwatka, 2429 Lancaster Street; 2nd, N. L. Dashiell, Jr., 700 S. Broadway; 3rd, W. H. Johnson. 1916 E. Pratt; 4th, C.F. Maguire, 4 S. Exeter; 5th, A. Wegefarth, 805 Aisquith; 6th, F. A. Sauer, 459 N. Central; 7th, C. H. Chabot, 1111 E. Preston; 8th, J. B. Saunders, 819 E. Chase; 9th, E. Micheau, 407 S. Sharp; 10th, A. Horn, 697 W. Mulberry; 11th, J. A. Gilliss, 437 W. Biddle; 12th, T. P. McCormick, 1421 N. Eutaw; 13th, Wm. Wolf, 658 W. German; 14th, J. C. Wunder, 1075 W. Fayette; 15th, W. B. Burch, 509 Hanover; 16th, Joseph Blum, 641 Columbia; 17th, H. Stark, 1110 Hanover; 18th, H. Boyd, 677 Columbia; 19th, J. W. Linthicum, 1327 W. Fayette; 20th, A. L. Hodgdon, 1235 Lafayette; 21st, W. A. Duvall, 2303 Rayner; 22nd, H. G. Prentiss, 809 Gorsuch.

It will be seen from the above list that the increase in the number of vaccine physicians, which the profession has repeatedly urged upon the city government has at last been effected. The force is now nearly double what it was a year ago.

The *Sun* reports the sad death, on November 22nd, of a Baltimore physician, Dr. Henry J. Houck, from accidental poisoning. While at Ocean City, Maryland, he suffered from insomnia, and going with the lady in charge of the Atlantic Hotel into the drug-room of the hotel, he took up a bottle labeled "Hyd. Chlor. Cor.," which in the indistinct light he supposed to mean hydrate of chloral, and swallowed a fatal dose. An hour later he was found dead in his room. He was about fifty-six years of age, and had retired from practice.

To those of our readers who have studied in Europe it will be interesting to learn that the Society of American Physicians in Berlin celebrated Thanksgiving most appropriately with a banquet, to which the American minister and consul-general were invited; and closed the evening with a ball. There is nothing which develops the latent patriotic instincts of the American in these times of peace so much as a Fourth of July or Thanksgiving spent in exile among foreigners.

Reviews, Books and Pamphlets.

The Anatomy of the Peritoneum. By Franklin Dexter, M. D., Assistant Demonstrator of Anatomy, College of Physicians and Surgeons (Columbian University), New York. With 38 illustrations. New York: D. Appleton & Co., 1892. Small octavo, 86 pages.

Believing that there is no way of gaining a clear idea of the peritoneum except through a knowledge of its development, Dr. Dexter presents to the medical public a guide which will lead the student step by step along the development of the peritoneum, up to the important relations which it sustains, in the adult, to the great abdominal organs. The book consists of a series of neat colored plates, with descriptive remarks concerning each separate plate and subdivision of the peritoneal tunic.

Why Hygienic Congresses Fail. Lessons Taught by the International Congress of 1891. By Dr. Elizabeth Blackwell. London: George Bell & Son, 1892. Price 1 shilling; 40 pages, paper.

Acne and Alopecia. By L. Duncan Bulkley, A. M., M. D., Professor of Diseases of the Skin, New York Post-Graduate Medical School. George S. Davis, Detroit, Michigan, 1892. Paper, 83 pages.

In this number of the Physicians' Leisure Library the author presents the two subjects as they appear to one daily engaged in relieving both conditions, for the benefit of physicians having fewer clinical advantages in this line of practice. The volume is carefully indexed.

The Medical News Visiting List, 1893. Thirty patients per week; price $1.25. Philadelphia: Lea, Bros. & Co., 1892.

This is one of the very best we have seen. It contains full tables of metric equivalents in scale form; directions for urine examination; a table of thera-

peutic reminders (list of diseases and their treatment); directions (illustrated) for ligation of arteries; and a department for clinical records of cases. The only objection we find to it (which many would consider an advantage) is that the pages for daily visits are headed with the *name* of the month and *number* of the day of the month. Both of these should be left blank, so that if one page is not sufficient, or is marred, the next page may be used instead. It is, however, a very excellent book.

Medical Progress.

TREATMENT OF CERTAIN MOUTH DISEASES.

In the *International Medical Magazine*, Dr. Dessan writes:

I have for some years entertained the opinion that the affection so commonly seen in children, known as follicular tonsillitis, or *angina lacunaris*, is due to gastric disturbance, either from improper food or over-feeding. This view is strengthened by the result of treatment, which is a confirmation of the old aphorism that "the cure shows the disease." My treatment for this affection is entirely internal, the difficuity of making local applications in cases of very young children being thus avoided. I give calomel in the form of the palatable tablet triturate, one-tenth grain each, every two or three hours, for two or three days, and the successful result is prompt.

I have referred to follicular tonsillitis at such length for the reason that I am inclined to place this affection, as well as aphthous and follicular stomatitis, in the class of herpetic affections. They are, in my opinion, due to a similar original etiological factor as herpes, and in this regard I am pleased to find myself concurring with the views of Dr. Forchheimer, as expressed in his article on "Aphthous Stomatitis" in the May number of the *Archives of Pediatrics*. No better treatment in these affections of the the mouth and pharynx in children can be found than fractional doses of calomel, given in the form of the tablet triturate, one-twentieth to one-tenth grain each, every two or three hours. In such doses calomel acts as an undoubted stimulant of the liver, one of the five functions of which organ it is to destroy the poisons formed in the process of both normal and abnormal digestion of food, and to prevent their entrance into the general circulation of the blood.

A CASE OF FILARIA IMITIS.

An illustrated article upon infection by this parasite is found in the November issue of the *International Medical Magazine* from the pen of Dr. Van Meter, from which we extract a few paragraphs:

Some months ago a friend requested me to look at a fine water-spaniel, which had been recently sent him from the low, marshy lands of Arkansas. For some days past he had been sick, refusing food, and showing marked signs of discomfort. A week previous he was seen to fall in a faint, and his urine was noticed to be very bloody. When I first saw him, the poor animal was panting, restless, and wore a most anxious look, which appealed to one for aid, as much as would be possible by any supplication of words.

His respirations were between 35 and 40 per minute; heart-rate about 140. The examination of the lungs was wholly negative, but the respiratory sounds were almost entirely masked by the continuous cardiac murmur, which was audible

over the lower portion of the thorax. The first and second sounds were indistinguishable and very faint. On palpation, a marked thrill could be felt over the lower half of the chest. The cardiac impulse was diffused, and imparted that sensation of labored action to the hand so significant of dilatation. The opinion given was that the dog had some cardiac lesion, the exact nature of which I could not make out, but that dilatation was taking place. That, perhaps, coming from a lower to a higher altitude had proven too much for the already disabled organ. Two days later he died, and being desirous of completing my diagnosis, I made a post-mortem examination, with the following result: All organs passively congested—most intensely so. The kidneys were so engorged with venous blood that they were of indigo-blue color. Their pelves and the urinary bladder were filled with a liquid looking more like blood than urine. Each and every part was carefully examined, and nothing pathological, save the passive congestion, was found, until the heart was reached. On opening the pericardium we found no fluid. The heart appeared hypertrophied, judging from the size of the animal, and spherical as if dilatation had progressed to a marked degree. On severing the blood-vessels at the base, I cut through what at first was supposed to be a fibrous clot, but which proved to be a roll of filariæ (Fig. 1). When the ventricles and auricles were laid open, they were found filled with a tangled mass of these parasites. They extended in the vena cava, the pulmonary artery and vein, but not into the aorta. On close inspection the intra-auricular septum was found to be perforated, and a roll of fifteen or twenty filariæ plugging the perforation. This roll was continuous with the mass in the left ventricle, which seemed to be doubled upon itself; and from all appearances I am of the opinion they gained entrance to the left heart through the inter-auricular septum. Either that, and the animal died before the blood-current had time to carry them into the aorta, or else they had the power to stem the current of the blood, for not one was found in the aorta. Instinctive anatomists they were, to choose the thinnest structure between the venous and arterial systems, if, in reality, they bored their way through the inter-auricular septum.

As can be plainly seen in the cut (Fig. 1), the mass of filariæ prevented every leaflet of the valves from performing its function. They not only obstructed the circulation by filling up the lumen of the vessels and heart, but rendered all the valves incompetent. They are so matted together that it is impossible to count them, but I feel sure there are not less than 250 or 300 of them. They did not extend into the aorta or vena cava; there was no signs of ante-mortem clot and but little tendency toward coagulation after death. This suggests that they fed upon or in some way removed the fibrin-producing factors, for certainly, had they not, such sieve-like action should have produced fibrous clots.

When an animal is once infected, it is only a question of time until it dies. Yet from observation of dogs dying of filariasis, it is known the condition may in some cases exist over quite a space of time, and in others be of rapid course. Fortunately, but few cases have been reported in man; hence, the malady does not attract attention, and create fear and horror, as do the more common fatal or incurable diseases.

The filaria imitis is found in warm countries. The fully-developed parasite is from seven to twelve inches in length, three-hundredths to six-hundredths of an inch in diameter, tapering at either extremity, and of a pale-yellow, waxen color, resembling strands of catgut as they are seen filling up the cavities of the heart and large blood-vessels. The male is smaller than the female, the latter being

almost twice the size of the former and always found in greater numbers. Anatomically it resembles the other round worms.

So far as I know, no one has made an exhaustive study of the blood of animals afflicted with this filaria, although the Filaria Sanguinis Hominis, its nearest relative, has received much attention.

ENTRANCE OF AIR INTO VEINS.

Dr. E. Martin gives the following conclusions in the *International Medical Magazine,* November:

1. Air can be aspirated into a wounded vein by inspiratory movements, if through attachments or thickening of its walls the vessel cannot collapse. An elevated position of the part favors the entrance of air into a wounded vein.

2. A churning sound, heard on auscultating the heart, and the frothy blood from the proximal end of the wounded vessel are the only diagnostic signs of this accident, though a loud sucking or lapping sound, followed by collapse and local or general spasms, would strongly indicate that this complication had occurred.

3. Experiments upon animals show that the various species differ greatly in their power to resist the effects of air insufflation. Hence conclusions drawn from laboratory study are of little value in determining the influence of air in the veins of man.

4. A few small bubbles of air introduced into the veins of man are innocuous. The quantity capable of destroying life is unknown, but is probably proportionately far less than the quantity sufficient to kill the animals commonly experimented on.

5. Compression of the vein through which air is entering, between the wound and heart, free bleeding from this wound, the administration of cardiac stimulants, and, if the apparatus is obtainable, aspiration of the right ventricle represent the most efficient treatment for the relief of the overburdened right heart. Each minute that life is prolonged makes the prognosis more favorable.

ORIFICIAL COMMENTS.

"The September number of the *Medical World* is devoted entirely to malaria. Neither the writers nor the editors of this worthy journal seem to be cognizant of the fact that Orificial Surgery is the most reliable, satisfactory and speedy cure for chronic malarial conditions."

"In cases of spasms in young children, mere trimming up of the rectum and dilatation, accompanied with circumcision, relief of the tension of the frænum, enlargement of the meatus, may not be sufficient to correct the spasms. These young cases require dilatation of the urethra as emphatically as older ones do." (Now that the women are pretty much used up, the children's hour has come. Old men next !)

"If it should ever become universally known that sexual waste and irritation of the last inch of the rectum predisposed patients to fatality in this terrible scourge (cholera) what a decided interest would speedily be created in the study and practice of orificial principles, when the invasion of this dreaded disease was threatened."

"As the principles of Orificial Surgery become more widely disseminated, fewer ovaries will be sacrificed to the surgeon's knife; fewer women will fill premature graves, and the sleep of gynæcologists will be less frequently disturbed by nightmares of their mistakes and failures." (Good !)

"It is true that the insane are physically sick and can almost invariably be cured, but it takes Orificial Surgery to accomplish this to any considerable extent."

(And, again, with special reference to Dr. Rohé's recent article, the *Journal of Orificial Surgery* remarks): "Before gynæcologists are turned loose in insane asylums, it would be much better for the inmates if the doctors posted themselves a little more thoroughly upon the teachings of Orificial Surgery."

(This Orificialism is not a "fad." Oh, no! Its views of medical therapeutics are very, very refreshing. We look forward with eagerness to the next number of its most unique journal, which reminds us of the early efforts of Homœopathy.)

GUAIACOL FOR PHTHISIS.

Guaiacol, an ethereal product of beechwood which is soluble in two hundred parts of water, was recommended for its efficacy in tuberculous processes, in 1880, by Professor Max Schüller, of Berlin. In the *International Medical Magazine*, November, Dr. A. Jacobi, of New York, gives his experience with it. It is very unfortunate that he does not give a separate statement of results in the "half of the cases" which took nothing else than guaiacol. We should then have regarded his results as authoritative, while now they are merely suggestive. He says: When the first patients who took guaiacol—a few in September, more in October and November—turned up again in December or about New Year's, after most of them had been exposed already to the winter crowding, closed windows, and winter weather, I was surprised at the almost uniformly favorably reports volunteered by almost all. There was hardly one but looked better and felt better; even a few absolutely hopeless cases with large cavities asserted they ate better, slept better, and sweated less. Most looked fairly well, and their strength had improved. In almost none had the emaciation increased, most had gained flesh, one ten pounds in two months. I will say right here that in every case where the diagnosis was not absolutely clear without it, the examination for bacilli was made and their presence proven positively. In many, digestion and appetite had improved at once. Cough became looser, and after a month or two appeared to be more mucous and less purulent.

I have not felt justified, in a large number of cases, to limit my therapeutical endeavors to the administration of guaiacol alone. The employment of arsenic (mainly arsenious acid) and digitalis in some form or other has rendered me such eminent service in the treatment of tuberculosis, that in at least half of the cases I have combined them with the use of guaiacol. The best method of giving them is in the shape of pills; almost everybody takes readily two milligrammes of arsenious acid (gr. $\frac{1}{30}$) and two or three milligrammes of (Merck's) digitaline three times a day.

THE GIANT CELL OF TUBERCLE.

Conclusions.—1. Giant cells are cellular monstrosities, accidental and not purposeful, resulting from the growth of epithelioid cells.

2. This overgrowth is brought about by mechanical or chemical irritation caused by the presence of a foreign body, whether a living or dead micro-organism or some inert particle.

3. Being the offspring of a cell possessed of amœboid and phagocytic properties, the giant cell possesses them to some degree, as shown by the ingestion of foreign particles.

4. Whether living, active tubercle bacilli are thus devoured must remain *sub judice*.

5. The giant cell exerts no special deleterious influence upon the tubercle bacillus, but seems instead to be injured by it, a more observable degeneration occurring in those cells which contain many bacilli than in those which contain none.

6. The giant cell of tubercle does not differ essentially from giant cells elsewhere, except that it shows a more marked tendency to undergo cheesy degeneration, a fact probably due to the peculiar poisonous products of the bacilli in the tubercle.—Dr. J. McFarland, *International Medical Magazine,* November.

Recommendations of Therapeutic Agents.

Varied Uses of the Newer Antipyretics.—Introduced as modifiers of temperature, some of the medicaments of the aromatic schema appear to have been especially useful in the multiform conditions presented to the general practitioner. Phenacetine, especially, is widely called for in daily practice and it seems to have given good results even in obstinate conditions. In sciatica, for example, Dr. J. D. Blake (*Medical World,* October) directs the use of this medicament. He gives iodine, colchicum, etc., for the constitutional manifestations and phenacetine for the pain. He writes: "Give phenacetine, grs. v, when the pains are severe. A few doses will suffice. Try it." Professor Hare (*Col. and Clin. Record,* August) gave, in the treatment of supra-orbital neuralgia, cod-liver oil, adding phenacetine, grs. v, three-times daily. Dr. W. Minaker (*Medical World,* September) says: "An excellent combination for the treatment of malaria, and one which answers equally well with the large doses of quinine, is phenacetine, quinine and salol, of each 2 grs., repeated every three hours." A noticeable feature in the above instances of medication by phenacetine is the small size of what seems to be considered an effective dose of phenacetine. Dr. Porter (*La Sem. Med.,* No. 19, 1892) recommends phenacetine as a substitute for preparations of opium. He gives it in 2½ gr. doses, in combination with minute quantities of salicylic acid, cocaine and exalgin. Probably the phenacetine alone, in 5 gr. doses, would be better, as salicylic acid is not usually well borne, and some practitioners do not like to prescribe cocaine in simple conditions.

Medical Items.

The Jenner Centennial will be celebrated in Washington, D. C., in the year 1896.—*Ex.*

A case of failure of orificial methods has been reported in the *Journal of Orificial Surgery* for November. A man was afflicted with impotency (variety and supposed cause not given). "All-round orificial work was done, including the American operation, circumcision, and removal of a portion of the scrotum; yet after a year no relief is reported." Why portions of the penis, testicle and vas deferens were not removed, is not stated.

The highest Court of Germany has decided that legal human life dates from the beginning of labor, and that its destruction before full term is not murder. This decision opens a wide avenue of possibilities, and if sustained will encourage rather than check crime.—*Col. and Clin. Rec.*

The editor regrets that he was led into an unfair criticism, in the last issue of

the JOURNAL, of the transportation and hotel arrangements made for the semi-annual meeting of the State Faculty.

From other facts that have since come to our knowledge, it is evident that the arrangements were the best that could possibly be made under the circumstances.

We desire even at this late hour to express our appreciation of the committee's labors in planning the meeting.

A photographic paper for tracing purposes which gives black lines on a white ground is being introduced. It has the advantage over ordinary blue prints of giving more suitable colors for the ground and lines, and after exposure in the printing frame, the only treatment required for developing and fixing is the plain water bath. Such paper has long been desired by engineers. The point which has hitherto baffled the researches of chemists and inventors appears to have been the discovery of an organic substance which could be bleached by the sun, but precipitated as a dark purple powder when it and its suspending medium were brought into water. This has now been done. The powder used forms a dark deposit on the paper and is quite permanent. By the use of this paper the expense of developing chemicals is saved.—*Chicago News-Record.—Ex.*

There is a law in Massachusetts against the practice of docking horses, and the Society for the Prevention of Cruelty to Animals has succeeded recently in obtaining several convictions under its provisions. The law reads as follows: "Whoever cuts the solid part of the tail of any horse in the operation known as docking, or by any other operation performed for the purpose of shortening the tail, and whoever shall cause the same to be done or assist in doing such cutting, unless the same is proved to be a benefit to the horse, shall be punished by imprisonment in the jail not exceeding one year, or by a fine of not less than two hundred and fifty dollars. One half of all fines collected under this act, upon or resulting from the complaint or information of an officer or agent of the Massachusetts Society for the Prevention of Cruelty to Animals, shall be paid over to said Society in aid of the benevolent objects for which it was incorporated." A similar law was also passed at the last session of Congress for the District of Columbia.—*American Practitioner and News.*

The Anglo-American Vienna Medical Association fulfils a useful function towards English-speaking students who visit Vienna for purposes of study. It is difficult for a stranger to arrange his work to the best advantage without the advice of those who have already studied in Vienna for some time. The Association keeps a list of the best lodgings, and thus smooths the entry into Viennese school, and at the fortnightly meetings the new arrival is able to make acquaintances and obtain information. The second meeting of the Association this winter was held on October 14th, when about forty members were present. Dr. Blake, the President, occupied the chair. The Rev. Francis Gordon read a most satisfactory financial report for the past year, and was able to announce that forty-three new members had joined the society. Dr. Meirowitz then read notes of a most interesting case of hysteria in Vienna, illustrating many peculiar phases of the disease at present under treatment. In the discussion which followed many of those present related personal experiences in connection with the treatment of hysteria, some of which caused considerable amusement. Several papers have been promised for the ensuing meetings, many of them of great interest. The next meeting will be occupied in discussing the merits of Berlin as a medical centre. Further information may be obtained from the Secretary of the Society, No. 12, Landesgerichtsstrasse, Vienna.—*Ex.*

MARYLAND MEDICAL JOURNAL.

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Original Articles.

REMOVAL OF A FRAGMENT OF STEEL FROM THE VITREOUS CHAMBER BY MEANS OF THE ELECTRO-MAGNET, WITH PRESERVATION OF NEARLY NORMAL VISION.*

BY SAMUEL THEOBALD, M. D.,

Ophthalmic and Aural Surgeon to the Johns Hopkins Hospital and to the Baltimore Eye, Ear and Throat Charity Hospital.

The successful employment of the electro-magnet for the removal of fragments of iron or steel from the interior of the eye-ball has become of such frequent occurrence that one hesitates to report such cases unless they present features of especial interest. The fact that in the present instance the foreign body was not removed until the eleventh day after its entrance into the vitreous chamber, and the further fact that in an eye otherwise doomed to destruction nearly normal vision was restored through the magnet's efficient action, seemed features of sufficient interest to justify my presenting a brief report of the case to the Society.

C. H., aged 12 years, was first seen on April 1st, 1892, in the out-patient department of the Baltimore Eye, Ear and Throat Charity Hospital. Six days before, while striking a hatchet with a hammer, a small fragment of steel had

*A paper read before the American Ophthalmological Society, July, 1892. See also Transactions of the Society and American Journal Ophthalmology.

been broken from one of them and had struck his left eye with such force as to cause severe pain and much impairment of vision. The eye exhibited marked conjunctival injection, and upon close inspection a small scar was discovered at the upper and outer corneal margin, and just in line with this a hole in the iris, close to its periphery, of corresponding size. At the anterior pole of the lens, apparently just under the capsule, there was a slight opacity, and with the ophthalmoscope, besides numerous floating opacities in the vitreous, so much diffuse clouding was discovered that the details of the fundus could not be distinguished. Vision was found to be $\frac{16}{CXXV}$. There was little room to doubt that the piece of steel was in the eye, though owing to the clouding of the vitreous humor its location could not be determined with the ophthalmoscope, and its removal with the electro-magnet was proposed. The instrument not being at hand, the operation was postponed until the next day. On the following day the chloride of silver ("dry cell") battery with which I had provided myself failed to produce in the magnet (Hirshberg's) any but the most feeble action, and a further postponement was unavoidable. An interval of four days occurred after this before an opportunity to operate upon the eye presented itself. In the meantime the inflammation had not lessened and iritis had set in.

I had decided misgivings as to the likelihood of my efforts to remove the foreign body being successful, after so long an interval from the date of the accident, but it was evident that enucleation at no distant day was the other alternative and, influenced by this consideration, I did not hesitate to undertake the operation. Chloroform was administered and antiseptic precautions, consisting in the sterilization of the magnet point and other instruments with boiling water and the flushing of the conjunctival sac with sublimate solution (1 to 8,000) were exercised. A free longitudinal incision was then made through the conjunctiva, between the external and inferior recti muscle, behind the ciliary body, and the tissues dissected back so as to expose the sclerotic at this point. A Beer's knife was then passed through the sclerotic and inner tunics of the eye, making a longitudinal incision about 4 mm. in length. There was considerable hæmorrhage, but the vitreous showed no tendency to escape. Although it had not been possible to locate the foreign body, the greater amount of opacity in the outer and lower quadrant of the vitreous humor and the accessibility of this part of the sclerotic determined the site of the incision.

The magnet point, freshly sterilized, was now introduced a short distance into the wound and withdrawn. Examination of its tip showed that the fragment of steel had not been attracted to it. A second, third, and possibly a fourth introduction of the point, which was pushed farther into the vitreous chamber and turned in various directions, failed as completely to accomplish the desired result, and I almost concluded that it would be useless to make further attempts. I determined, however, to try once more, and this time probably carried the magnet point nearer to the ciliary body than I had done before, and upon withdrawing it was rejoiced to find the bit of steel adhering to it. It was irregular in shape,

having one edge especially sharp, measured about $1\frac{1}{2}$ mm. in length, 1 mm. in width and $\frac{1}{2}$ mm. in thickness, and weighed but a fraction of a grain.

The magnet, which was operated by a single, small Grenet cell (zinc and carbon) was tested before the operation and found to be capable of lifting a pocket key-ring with four or five keys attached to it.

The after-treatment of the eye consisted in the constant application, by means of a bandage and linen pad, of a lotion of opium and boracic acid and the instillation of atropia. The improvement in its condition was rapid and uninterrupted, and when the patient left the hospital on April 23rd (seventeen days after the removal of the foreign body) the subconjunctival injection had greatly diminished and the vitreous humor was clearing rapidly; the opacity at the anterior pole of the lens was also less marked. Vision at this time was $\frac{16}{\text{XLV}}$. The pupillary margin of the iris, at a point corrsponding with the wound made in the cornea and iris by the entrance of the foreign body, had formed an adhesion to the lens capsule before the removal of the steel, and this persisted despite the liberal use of atropia.

The case was kept under observation in the out-patient department, atropia only being used, and continued to progress favorably. May 2nd, vision had improved to $\frac{16}{\text{XXX}}$.

At my request the patient called at my office a few days since (July 6th). No treatment had been practised for some weeks. The difference in the appearance of the two eyes was scarcely perceptible. The pupil of the injured one was not quite circular and there was just a trace of hyperæmia in the finer conjunctival vessels. In the neighborhood of the wound made through the sclerotic at the time of the operation, the hyperæmia was, of course, more marked, and there was still considerable thickening of the episcleral tissues at this point, but this could be seen only when the eye was directed upwards and the lower lid somewhat everted. The lad assured me that the injured eye gave him no annoyance whatever, and that he felt no dread of light. Upon examining the lens a very small, well-defined, circular spot of opacity was found just under the capsule at the anterior pole—the only remains of the more diffuse opacity observed in this part of the lens when the case first came under observation. The peripheral wound through the iris was easily found, but was less conspicuous than when first discovered. The ophthalmoscope revealed no opacities in the vitreous humor, and showed a normal fundus, except at the region of the sclerotic incision. The site of the latter was indicated by a linear white patch, and just in front of this, and separated from it by an isthmus of normal choroid and retina, there was another spot of atrophy, much smaller and circular in shape, through which the sclerotic could also be distinctly seen. I could make out no evidence of retinal detachment.

The small, circular area of atrophy, which was situated between the sclerotic wound and the ciliary body, marked, in all probability, the point where the fragment of steel impinged and to which it remained attached. If such was the case

the point of the magnet must have been in close proximity to the foreign body each time that it was introduced, and only failed to extract it at first because, as might have been expected after the lapse of so considerable a time from the receipt of the injury, it had become more or less perfectly encapsuled.

A test of the vision of the two eyes, both of which were decidedly hypermetropic, showed but a slight difference between them. With +75s, the left (the injured) eye had $V=\frac{20}{XXV}+$, and the right eye with $+87sV=\frac{20}{XX}$. The possibility of making a further improvement in the vision of each by means of cylinders was not gone into.

It is too soon yet, and probably always will be too soon, to say that an eye which has been through the experience this one has will never give trouble, but in the present instance I have little fear as to the future.

SOME EXPERIENCE WITH CHOLERA IN 1866.*

BY S. A. KEENE, M. D., OF BALTIMORE.

Mr. President and Gentlemen:—The part that I shall take in discussing the subject that is now agitating the public as well as the medical minds will be simply to recall from reminiscences of a time now quite remote some of the experiences I had in a short and limited encounter with cholera. It was in the fall of 1866, about the latter part of September, that cholera broke out among some oystermen while dredging in the lower waters of the Chesapeake Bay. The origin, as well as I can recollect, was attributed to a vessel hailing from Philadelphia, where the disease had been raging for two or three months.

From the long lapse of time you will hardly expect me to speak with positive accuracy of minute details; I shall therefore allude only to the general observations that were then impressed upon my mind. There will be no better time than now for me to say, and indeed with emphasis, to those who have never seen cholera, that there is no disease with which I am acquainted that will make as strong and lasting impressions as this most dreaded scourge.

I should hesitate long, if indeed I felt inclined, to say anything of the etiology of the disease, after the exhaustive treatise delivered in this hall two weeks ago by Professor Welch. My aim will be to summarize as best I can the more prominent clinical features as they now appear to my mind.

To those who have never seen oyster-dredging, I would like to say that generally a great number of boats, probably two or three hundred, huddle together upon the oyster beds and work during the day time; and at night or in bad weather, they congregate in some neighboring harbor, where they will exchange social courtesies in their small, contracted cabins, and in perfect accord with their own peculiar ethics. I need scarcely say that their mode of life and surroundings are such as to encourage a very thrifty germ propagation. It was

*Read before the Clinical Society of Maryland, November 18th, 1892.

among these people and amid such surroundings thatthe disease made its appearance, and, spreading with great rapidity, caused considerable mortality.

I saw my first patient about midnight; he had been vomiting and purging not more than an hour or two. I did not feel at all apprehensive over his condition, believing it to be an ordinary attack of cholera morbus. I had not then heard of the slightest suspicion of cholera anywhere nearer than Philadelphia. I prescribed opium and bismuth, to be followed by a purgative, and probably mustard poultices to the abdomen; and after waiting a reasonable time, I left him with no feeling of alarm, but rather with the assurance that, like other cases, he would soon be relieved. Early the next morning I started out on my rounds, intending to see my cholera morbus patient first. I had not gone very far before I met a messenger that wanted me in another direction. I did not hesitate to follow him and when I reached the patient I found him affected similarly to the one whom I had seen the night before. From him I learned for the first time that there was a disease prevailing among the oystermen dredging near James's Island, from which, to use his expression, they were dying like sheep; and that he and Slacum (my first patient), becoming alarmed, had left their boats the evening before, to come home, about 35 miles distant. On the way, Slacum complained of feeling badly; but when they parted, about 10 o'clock, he had not vomited. My second patient had slept well during the night and had been only aroused early that morning by a desire to evacuate his bowels. He seemed more scared than hurt, particularly after I told him I had been called to see his companion during the night. I prescribed the same medicine that I had given in the night, and, feeling a little more concerned about my first patient, I drove hurriedly to see him and to my amazement and consternation I found him not only in collapse, but dying. He died within an hour after I reached him—within 12 hours from the time he and his companion separated the night before and within 9 hours from my first visit.

I returned immediately to my second patient and found that vomiting had come on during my absence, and the purging had also increased; he seemed quite prostrate and very anxious. Really I did not know what to do. With a very limited experience (for I had only graduated 18 months before); all alone in a country place; having just left a corpse, and now standing before a most probably prospective one, you may well imagine my feelings. If I had never before appreciated the responsibilities of my profession, it is needless to say that now I realized them all. Opening my little armamentarium and thinking all the while what I should give, I could conjure nothing nor select anything more than what I had already given. During my perplexity the patient's old mother suggested that injections of red oak bark tea might be of service. I eagerly accepted the suggestion and before I could order it she had dispatched a messenger to the woods. The old lady knew how to make and give the injection, and needed no instruction from me, so I left, to consult my books, promising to return soon. About that time the *Medical News*, published in Philadelphia, was filled with

articles on cholera, and having preserved the copies, I found I had considerable matter to read through, much more than my quiet leisure would permit, for when I reached home there was another call, which I found to be a similar case. I will now condense this portion of my narrative by saying that within four or five days I had received seventeen calls to cholera patients, differing in degree and severity, all of them oyster dredgers and coming from the affected boats.

I gathered up my journals and read them as well as I could on my routes. I can well remember how difficult it was to settle upon any special line of treatment, for the different authors did not agree any better then than now; and I found no encouragement or relief from my dilemma. Opium seemed to be the only remedy agreed upon; but I had tried it and seen it fail. I had already learned that time was valuable and that action must be prompt—I had just seen a strong, hearty man prostrated unto death within twelve hours. I had corroborative testimony in the information that the dredgers were dying like sheep; a whole boat's crew, numbering six, had died during one night; another boat had started to work in the morning, and a short time after was noticed to be acting strangely, and when the captain of a neighboring boat boarded her, he found the whole crew in the cabin unable to help each other, and one after the other died. With all this before me I could but reflect, and was constrained to believe that the tendency to exhaustion could be best met by stimulation, and for that purpose I combined chloroform, tr. camphor, tr. capsicum, tr. opii and brandy, of which I gave liberally and frequently. I was pleased with the effect—it not only stimulated, but relieved the cramps, which is the most excruciating suffering, and I believe had a controlling influence over the vomiting. At any rate, 16 of the 17 cases recovered. I will again revert to my second patient; when I returned I found him much relieved of the purging and in every way better, and by the next morning he was well. This was the mildest case that I had. I have no doubt that the red oak bark injections were of great benefit to this patient. For if there is any virtue in tannin, as is claimed by some authorities, I am not surprised that in this case it did good—for the old lady made a very strong decoction, and did not hesitate to use it frequently and in goodly quantity, so much so that I dreaded the result upon the intestinal membrane. There was, however, no trouble, and the old lady took to herself the credit of the cure. I adopted it in all the other cases, but not of the same strength as she used it. Right here I might suggest a theoretical as well as a practical question: Was it the tannin in the decoction that dimihished the purging, or was it the filling of the bowels with fluid that arrested the transudation into them? Were I to answer the question, I could not decide theoretically in favor of either; but would express a practical preference for both. If it is true (and to my mind there can be no question about it) that in cholera all the fluids of the body are transuded into and evacuted through the intestines; that if you can arrest that transudation either by the effect of astringents upon the intestinal membrane, or by filling the intestinal canal with a fluid that will not only resist but will repel the

exosmosis, much is accomplished towards reinstating the natural physiological law of endosmosis. Probably there may be a rebuttal to this by the theory that in cholera, the primary essential change is not in the solid structures of the alimentary canal; but that it is a toxæmia, and that the poison is eliminated best by fluxion through the intestines, being the largest and most convenient—in fact, the only excreting avenue; and that the larger and more frequent the evacuations the sooner the poison is eliminated, and therefore no effort should be made to restrain them and prevent a favorable result. While a few cases of cholera sicca have been reported where persons have died without ever having either vomiting or purging, I am very confident that by far the greater number of deaths have been not only preceded, but in very great part have been due to the exhaustion and solidification of the blood caused by the excessive evacuations. I should certainly not hesitate, if again an opportunity presented, to do my utmost to restrain them, and I would incline very much to enteroclysis; I would aim to fill the intestinal canal as thoroughly and as frequently as possible, preferring some astringent fluid, and I would again allow patients to drink as freely as their thirst demanded, not only to satiate the intolerable anguish, but with the view of arresting the transudation into the stomach, and in this way stop the vomiting.

Cholera evacuations are very copious, much more abundant than the fluid injected, which proves that there is a hypersecretion or morbid transudation into the stomach and intestines. They differ from those of cholera morbus, that they contain no undigested food; certainly after the first few evacuations; they consist of a thin liquid resembling whey or rice water, containing small flakes like curd, with no odor, no bile and no fæces. They are accompanied by neither pain nor nausea. The vomiting is secondary to the purging; it occurs suddenly, without any premonition, and is irrepressible. It appears to arise simply from over-distention of the stomach.

While vomiting and purging are very characteristic symptoms of the disease, they are, however, relatively disproportionate and variable; the one may diminish or cease and the other become more aggravated. Associated with them is a feeling of prostration, more or less feebleness and frequency of the pulse, and cramps of the muscles of the limbs. The attack may end spontaneously or be arrested without advancing beyond this stage, which may be distinguished as the stage of invasion. All the symptoms cease, convalescence is at once declared and recovery is rapid. The duration in such cases is brief—a few hours only.

A large proportion of cases, however, does not pursue such a favorable course. A group of striking symptoms develop and the disease passes into a stage of collapse. The pulse continues its feebleness, but loses its frequency and drops below normal; it weakens until it becomes imperceptible at the wrist and scarcely discernible in the carotids; the heart-sounds are hard to recognize. The blood deprived of its fluidity stagnates in the capillaries and veins, chills and discolors the surface and covers it with a copious viscid perspiration. Robbed of its fluid, the skin is withered and wrinkled, the nose pinched and made prominent by the

sunken cheeks; the eyeballs only half concealed by the rigid and inactive eyelids, the mind apathetic, listless and indifferent to danger—such was the condition in which I found one of my most intimate friends within a few hours after he was taken; from a strong, vigorous young man he had been transformed into a prostrate weakling. He was so changed in appearance that I did not recognize him; I could not trace a single line of health among his then ghastly features. He begged pitifully for water which had been until then denied him; his tongue was swollen and cracked. I procured the water in a small tin bucket, and as I held him up he clutched it in his trembling hands, and gulped it down, and as he drank, it would regurgitate back into the pail, to be again retaken, until at last he fell back upon his pillow, and were it not for the sighing respiration I would have thought him dead; but he revived. I was surprised to see him rally, and more surprised still to hear him a few days after demand some pork and beans for his dinner. He would neither hear counsel nor heed advice; but have it he would; he ate it, and with impunity.

I have recounted these two extremes, and offer the varied intermediate conditions as having constituted the rest of my experience. They all passed more or less into the stage of collapse, from which they emerged into convalescence with surprising promptness and rapidity. In no instance can I recall that troublesome sequelæ ensued. It is indeed surprising to the observer, and will no doubt cause wonderment, if not disbelief, in the minds of the inexperienced, when told how rapidly a patient, who only a few hours before appeared to be *in extremis*, will not only revive, but, in a day or two, will be himself again.

It is certainly a peculiar disease. Within four or five hours one may pass from apparently perfect health to the cooling board; or within forty-eight hours another may pass through the stages of invasion, collapse and reaction, into restored health, with ravenous appetite and good digestive function. Such prompt and rapid recovery would indicate that there are no essentially morbid changes in the solid structures of the alimentary canal, and whatever the blood changes may be, they are transient and admit of speedy readjustment.

The little outburst of cholera, a partial account of which I have endeavored to give, was of short duration. It did not last more than two or three weeks, and in accordance with its peculiar characteristic, its greatest virulence and mortality was in the beginning. The cases I saw were not in the places infected, but were removed to their homes, many miles away. It did not spread—there was but one case about which I had any suspicion of contagion, and that was the wife of one of my patients who had a slight gastro intestinal irritation. About the only disinfectant I used was lime. The dejections were buried.

Cholera is not regarded now as it once was. Very few will say that it is contagious; all do not believe it is infectious. There is more unanimity in the belief that it is not yet understood; and all will agree that of the various and complex problems, which the "Pathology" of the future will doubtless finally solve, certainly not the least important will be those of the active causes, and

practical means of prevention and cure of specific, infectious and contagious diseases; and there is not one so ranked that will give the "bacterio-pathologist" greater interest, more concern, nor deeper study than cholera. For us, standing as we must, in contentment, upon the bridge that spans the chasm between the past and the future, we can only retrospect the panorama of the past, and look with confiding hope for more real development in the experiments of the future.

1520 Druid Hill Avenue.

AN ORIFICIAL CASE.

As we never heard before of "almost continuous stricture throughout the whole length of the urethra" resulting from a blow upon the skull, and causing left temporal neuralgia, we insert the following case, which reflects light on the marvellous diagnostic acumen of one of the editors of the *Journal of Orificial Surgery* (November, 1892, page 362):—

Case I.—W. S., aged 28. Syphilitic history; complained of intense, constant neuralgia in the left temporal bone over ear. Six months before this complaint began, he was struck on the head with a club, and, with the exception of the ordinary conditions that would necessarily follow a severe blow on the head, severe enough to cause unconsciousness for several minutes, no unpleasant consequence arose.

The neuralgia of which he complained was of such intensity as to prevent his sleeping at all. He could not work, was fast losing flesh, and, when first seen, presented a very deplorable condition. Drugs, electricity, poultices, etc., were tried, but all were ineffectual. Morphia alone gave relief, but of course only temporarily.

January 10th, 1891, the patient was anæsthetized, and, on examination, it seemed as though there was almost a continuous stricture in the urethra throughout its length. It took an hour to insert into the bladder the smallest filiform bougie. Gradual dilatation was practiced until a No. 15 English sound was introduced. The meatus urinarius was enlarged, as it presented a contracted condition. The rectum, on examination, disclosed three papillæ and four pockets, which were removed. The sphincters were thoroughly dilated.

The patient made a good recovery from the work and for two weeks after the operation was entirely without the neuralgia. Then the condition returned. Graduated sizes of steel sounds were used in the urethra, which relieved him to some extent, but not entirely.

He was then put on potash iod. five grs. t. i. d. and after one week the neuralgia had entirely disappeared. The patient gained strength and flesh, and now, after eighteen months, he has not had a return of the neuralgia and is in better health than he has ever been. He had taken the potash before the operation, but without benefit.

At a meeting of the Board of Trustees, held on Wednesday, November 30th, 1892, Dr. G. E. de Schweinitz was, on the unanimous recommendation of the Faculty, elected Clinical Professor of Ophthalmology in the Jefferson Medical College.

At the time of election, Dr. de Schweinitz was Professor of Ophthamology in the Philadelphia Polyclinic, and Lecturer on Medical Ophthalmoscopy in the University of Pennsylvania.

THE MARYLAND MEDICAL JOURNAL.

A Weekly Journal of Medicine and Surgery.

A. K. BOND, M. D., Editor.

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BALTIMORE, DECEMBER 10, 1892.

Editorial.

THE NEW DECIMAL ASSOCIATION.

We have received a pamphlet announcing the formation in London of a "New Decimal Association," which has for its object the awakening of the British public to an interest in the adoption of the decimal method of weights, measures and coinage. In view of the fact that modern prophets assure us that English is to be the prevailing language of the human race, we think our British brethren had better adopt our system of dollars and cents in coinage. We might, on our part, revive the old fractional coins, the "fippenny bit" and "levy," which have unfortunately been allowed to fall into disuse; and would be willing to call our "quarters" "shillings," out of respect to John Bull's feelings.

In regard to the use of the decimal system in prescriptions, we have no objection to it, since we do not take other doctors' medicines. If we were the public we would feel a little "skeery" of the decimal point in the hands of the absent-minded doctor; and would prefer to wait until we were dead and gone before we urged its use, since it is less dangerous to take eight times the amount intended (when 3 has been written for ʒ), than ten or one hundred times the amount (when the doctor disremembers how many ciphers ought to go after the dot). If these "furrin" ways should be made compulsory, we would either be driven to self-medication with Thomsonian teas, or would insist on the doctor writing his prescriptions in "plain English."

OUR WEEKLY CHRONICLE.

A HOSPITAL FOR INFECTIOUS DISEASES.

The most important event in the medical sphere which has come to our notice during the past week is the effort put forth to influence public opinion, and thereby to secure legislation, in favor of the establishment of a separate municipal hospital for the isolation and treatment of infectious diseases. It is stated

took out the stiches and removed the dressing, and said that there was no doubt but that the fingers had united, and that the man seemed to have sensation at the ends of his fingers, although he thought that this sensation might have been transmitted. The man then disappeared entirely from view. He returned about a month ago with an injury to his other hand. It is difficult to say, at first sight, which hand was injured. There is a slight motion in the joint which was opened, and the sensation in the fingers is perfect.

Dr. Randolph Winslow: This case of Dr. Finney's calls to my mind a case which I had about fifteen years ago. I was called one day to see a woman who followed the occupation of an upholstress. She had chopped the end of her thumb off with a hatchet, perhaps half an hour before I saw her. Upon inquiry about the missing piece, I was told that it was about the floor somewhere. I hunted it up, cleaned it, put it on with adhesive strips, and it is there to this day.

It is rather an important matter that we should replace these lost parts, and in many cases we will have success. I have a number of times replaced parts which were essentially cut off, attached by a minute portion of skin, with successful union.

1519 N. Broadway. W. T. Watson, M. D., Secretary.

Correspondence.

ROTARY DISLOCATION OF THE PATELLA.

Charleston, W. Va., November, 1892.

Editor Maryland Medical Journal:

The article in your Journal of November 12th, on "Rotary Dislocation of the Patella," recalls to mind a similar case to which I was called some years ago: A young man (a farmer), running after a hog, slipped and fell, dislocating the patella. The patella was directly on its edge. No amount of force that I could apply with my hands would move it in the slightest degree. I told him I would go home (six miles) and return next morning with Dr. M., an old practitioner who, deservedly, had the confidence of the whole community. That night I consulted my Surgery—next morning visited the patient with Dr. M. Did not tell him I had consulted the Surgery; wanted him to fail as I had done the evening before. All his efforts were fruitless. He said it was as immovable as if it had grown fast in that position. Getting on my knees, his leg on my shoulder, my hands on patella, flexed his thigh on pelvis, and, with very little pressure the patella turned back in its place. Common sense does not always come to our aid in case of emergency. Extend the leg, flex the thigh.

Anæsthesia will relax. It will not shorten the distance between the origin and insertion of a muscle. Position, in most cases, will. I doubt if the patella is ever dislocated, except when the leg is extended and the thigh flexed. I may not be so fortunate should I ever have another case.

Yours fraternally, W. P. Ewing.

Reviews, Books and Pamphlets.

Uses of Water in Modern Medicine; Vol. II; By Simon Baruch, M. D., Attending Physician to the Manhattan General Hospital; Consulting Physician to the Montefiore Home for Chronic Invalids; formerly Chairman of the South Caro-

lina Board of Health, etc. (Physicians' Leisure Library). George S. Davis: Detroit, Michigan, 1892. Paper, 25 cts., 228 pages.

We had the pleasure, some time ago, of noticing with approval the first volume of this treatise upon Hydrotherapy, by Dr. Baruch, who was a pupil of Dr. Winternitz, the great pioneer in this department of Modern Medicine.

In the present volume, the various sorts of wet packs and baths are described in detail, with several excellent illustrations; and the therapeutic indications for their application are given, with quotations from many clinical cases. We cannot undertake to personally criticise the statements of the volume on these points; but we would heartily recommend the little work (both volumes) to those who desire to know what it is attempted with, and what is claimed for, this therapeutic agent, which has been hitherto much neglected by the American profession. As the author says in the final chapter, "the best consultants in Germany, Italy and France—men like Leyden, Nothnagel, Binswanger, Senator, Ziemssen, Erb, Semmola, Dujardin-Beaumetz and Charcot—send their patients (in suitable cases) to the hydrotherapeutic institutions, which are under the charge of trained physicians." It will eventually be so in America.

Fissure of the Anus and Fistula in Ano. By Lewis H. Adler, Jr., M. D., Instructor in Diseases of the Rectum in the Philadelphia Polyclinic. Paper, 78 pages, freely illustrated, 25 cts. (Physicians' Leisure Library.) 1892: George S. Davis, Detroit, Michigan.

We know of a case where a country physician refused to treat a gentleman for fistula in ano, stating that his own life had been burdened for years by the same disorder. It is time that physicians everywhere waked up to the importance of anal fissure and fistula, which often exist for years under the deceptive name of piles, rendering patients miserable; and are almost wholly neglected in infants. To aid in such awakening of the profession, Dr. Adler presents this cheap work, containing the results of his experience and study of such cases. It is astonishing to find such a cheap work illustrated so well and with such an abundance (47) of good cuts of instruments and anatomical regions. Diagnosis and treatment, palliative and operative, of both conditions are given. We recommend the volume to the attention of those who want a cheap monograph on these subjects.

Medical Progress.

CHRONIC DYSPEPTIC STATES TREATED BY MENTHOL SPRAY THROUGH THE STOMACH-TUBE.

In the *International Medical Magazine*, November, Dr. A. L. Benedict reports several cases and says:

The technique of the administration of menthol through the stomach-tube is simple. The patient should be directed to take no food within at least four hours of the time of appointment and the last meal should be a light one. Lavage is practised in the ordinary way, using plain water or a weak alkaline solution of about the body temperature and repeating the washing until the fluid returns free from shreds of mucus. The water is removed from the stomach by siphonage as completely as possible, stripping and shaking the tube to remove

in the public press that a resolution having this as its object will be introduced into the new City Council when it meets in January.

Hospitals for infectious diseases are well known in England, where they have, as far as we have read, been of some benefit. As a considerable percentage of cases sent to these hospitals in England are found not to have any infectious complaint and so are, by their removal to the hospital, unnecessarily exposed to the infections which abound in its wards, it is obvious that the utmost skill in diagnosis is needed on the part of the sanitary inspectors who send the patients to the hospital, and that the hospital ought to be built upon a scale sufficiently extensive to afford not only separate wards for each separate infectious disease in each sex; but also a considerable number of detention-wards for patients whose disease has not been diagnosed with absolute certainty. This involves the outlay of a large sum of money by the city, and will render necessary the appointment of *medical men* as sanitary inspectors, instead of the non-medical inspectors who now investigate, or are supposed to investigate, cases of infectious disease reported to the Health Office. If the inspection is to be made in an unskillful way, and the patient is to be torn away from home and friends and hurried off, under mere suspicion of infectious disease, to an ill-kept hospital where he is liable to get other diseases than he had at the start, we would not blame the friends of the sick for concealing the existence of the infectious ailment and even doing without medical attention.

What we need is, not a St. Helena at Fort Carroll, where the sick may be imprisoned like convicts; but a handsome hospital in some healthy part of our suburbs, with a sufficiently extensive enclosed park about it to make it a delightful home for the sick and at the same time prevent the infection of the adjacent residences.

If such a sanitarium (for it should be a place so wholesome and bright that these naturally self-limited diseases will be persuaded to manifest even less severity than in the city dwellings) be furnished by the municipal government, the poor, who live in unwholesome homes where isolation is absolutely impossible, will in time learn to welcome the opportunity to send the sick away for isolation and quicker convalescence.

If the city government proposes to build cheap, gloomy lazarettos, we believe it had better not touch the matter at all, but let the community take its chances as at present.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD NOVEMBER 18, 1892.

The 271st regular meeting was called to order by the President, Dr. William E. Moseley.

Drs. T. C. Gilchrist, Theodore Cooke, Jr., and James McShane were elected to membership.

Dr. S. A. Keene read a paper on PERSONAL EXPERIENCE IN THE CHOLERA EPIDEMIC OF 1866. (See page 136.)

Dr. W. T. Howard, Jr., read a paper on HEART HYPERTROPHY; ANALYSIS OF 105 CASES FROM THE AUTOPSY RECORDS OF THE JOHNS HOPKINS HOSPITAL.

Dr. A. C. Pole read a paper entitled A CONTRIBUTION TO THE LITERATURE OF FOREIGN BODIES IN SURGERY. On September 7, 1885, G. W., who was assaulted by a crowd of roughs, presented himself to Dr. Pole with an incised wound between the anterior and the upper part of the auricle and the temporal bone. The wound was examined and cleaned and as a foreign body was neither seen nor suspected, the wound was stitched and dressed, and in a few days it was healed by primary union. Two years later the patient had a discharge from the ear, and behind a fungus-like growth could be felt what seemed to be a projection of uncovered bone. He was seen by an eminent specialist, who attempted at several sittings to remove the "bone," but without avail. Examination from time to time showed that the projecting body was lowering in the auditory canal and was becoming slightly movable. September 22, 1892, the patient was anæsthetized and Dr. Pole removed through the external auditory meatus a piece of dagger blade measuring $\frac{3}{32}$ of an inch in length, the point having entered the posterior wall of the canal and penetrated into the mastoid cells to the depth of about $\frac{5}{8}$ of an inch. The piece of blade had been in this position for seven years. He has been relieved entirely of severe neuralgic pains from which he had suffered for several years past.

Dr. J. M. T. Finney related a case of SEVERED FINGERS REAPPLIED SEVEN HOURS AFTER ACCIDENT WITH PERFECT UNION, AND RECOVERY OF MOTION AND SENSATION. On January 2, 1890, the patient, a machinist by trade, came to the Johns Hopkins Hospital about half past 12 o'clock, giving the following history. He was a machinist by trade and was running the engine in the absence of the regular engineer in a tin shop. He went to work about five o'clock that morning, and a little later, while going about a machine used for chopping blocks of tin, he dropped something, and while stooping down to pick it up his hand slipped under the knife and the ends of the middle and ring fingers were cut off. The middle finger was cut off just beyond the last joint. The joint was opened. The ring finger was cut off just above the root of the nail. This occurred, the man said, about half past five o'clock. He wrapped up the stumps and went home, where his wife covered the wounds with beeswax. He arrived at the hospital at the time previously stated. I asked him where the stumps of the fingers were and he produced them, wrapped up in a piece of newspaper. They were very cold, almost frozen. I placed them in a basin of warm water, using no antiseptic, because bichloride or carbolic acid might cause a layer of coagulation necrosis and prevent union. I scrubbed up the stumps of the fingers with a 1-2,000 warm bichloride solution, then I carefully rinsed them off in warm water. This process consumed at least half an hour. Then I took a shaving off the ends of the fingers so as to have a perpectly fresh surface. The stumps were treated in the same manner. The bone was scraped. I sewed them on, using four stitches in each case. I then applied strips of crepe lisse with collodion the whole length of the fingers on each side. These held the severed portions in exact apposition. Then I used other strips around the fingers, binding them together, and then applied a palmar splint and used a large absorbent dressing. He came back in a week and when the dressing was removed the fingers looked very well. I reapplied the dressing and told him to report in another week. Dr. Brockway saw the case on his return at the end of the second week. He

eclampsia is believed to depend on the surcharge of the brain tissues with excrementitious substances.

Herter, of New York (*N. Y. Med. Journal*, September, 1892), in a recent essay, calls attention to the numerous putrefactive products of nitrogenous foods, which form in the intestine when digestion of such foods is imperfect. Estimating these putrefactive products by the etherial sulphates which appear in the urine, Herter has studied their relation to epileptic attacks, and believes to have found some degree of correlation between the formation of such substances and the convulsive seizures, and at any rate an abnormal degree of intestinal putrefaction in epileptic neurotics. Those recent researches tend to focus and accentuate the convictions which many observant physicians must have formed, that the irritative phenomena of neurasthenic conditions are probably traceable to the immediate action on nerve centres of toxic substances circulating in the blood.

It is known that the forms of neurasthenia which are characterized by mere simple debility, are often wonderfully benefited by an excessive meat diet. This determines an excess of nitrogenous metabolism which, when well borne, is a most powerful stimulant to the nutritive processes of nerve centres. In irritative neurasthenias, however, the milk diet is often far better tolerated, and the explanation is probably to be found in the fact that on such diet the various perversions of nitrogenous metabolism are reduced to a minimum.

In the case in question I resolved to experiment with both diets, and began with the meat, intending to administer a pound and a half a day. However, in the first two days the patient only succeeded in taking three-quarters of a pound a day, and on the third came to me in a very curious condition. Her habitual air of quiet depression had changed to great restlessness. Her respirations were 28, somewhat panting; her pulse 120, feeble, the sphygmograph showing a marked respiratory curve. Her mouth was parched, she felt feverish, but, though she had continued to drink a great deal of hot water, the urine had become scanty and high colored, and the urethral burning was intense. She had been unable to sleep the previous night, was nauseated, and had contracted an intense repugnance to even the thought of animal food. In spite of the restlessness the patient was drowsy. This condition, produced as promptly and distinctly as if in a laboratory experiment, suggested several explanations, and, unfortunately, there was no opportunity to analyze the urine in such a way as might aid in the choice between them. Thus there was the possibility of a uric acid saturation of the nerve centres, an improbable theory, as the symptoms were quite different from those habitually associated with uric acid excess or retention.

The drowsiness especially suggested that peptones, insufficiently modified in the liver, had passed almost unchanged into the circulation, as in Lauder Brunton's experiment,

From a third point of view, the imperfect digestion of the meat had resulted in abnormal putrefaction in the intestine, with generation of toxic substances, which, passing into the blood, had occasioned the entire cortége of pseudo-febrile symptoms. This, on the whole, seemed the most plausible hypothesis.

The most important practical fact was the great aggravation of the urethral burning or paræsthesia under these circumstances, which certainly tended to confirm my hypothesis of its origin in constitutional conditions. The diet was changed to one exclusively of milk, three quarts a day. Two days later the patient returned, seeming a different person. The restlessness, hurried respiration and

nausea were gone; the pulse dropped to 84, the urethral burning and ovaralgia disappeared, the patient feeling for the time quite comfortable.

LIGHT AS A CAUSTIC.

In a very interesting article by Dr. Arnold in the *Pacific Medical Journal*, November, there are some striking passages concerning the caustic effects of light, with and without its accompanying heat-rays. He says:

For practical purposes the heat-rays can be filtered out of a beam of sunlight with a flat cell filled with a strong solution of alum, the most eligible athermanous material; and concentration of the light may be increased about twenty-fold before the painful effects of heat concentration are experienced. A common whiskey flask free from flaws, filled with alum solution and a lens, such as is sold for examining photographs, will serve for all minor purposes. This degree of concentration I have frequently employed on boils, warts, ringworms and the like, with instructive results; although they are too inexact from the trifling nature of the cases and from the absence of control experiments to describe them in detail.

I have secured distinct escharotic effects from a greater degree of concentration, although cosmoline would barely melt at the focus of the lens, a temperature of about 125° F.; and that effect was attained in two cases with a slight pricking sensation hardly amounting to pain, although the entire thickness of skin was reduced to a whitish, pulpy mass. This agrees with the Russian's observation already referred to, and with Dr. Thayer's experience, in which the simple burning glass was used without anæsthetizing the patient. The pain after a time was not complained of, notwithstanding the high temperature developed at the focus of the lens. He records as the principle objection to the treatment the unpleasant appearance of the operation and the odor and the smoke from the burning-flesh.

Since 120° F. is about the limit of usual toleration of moist heat, and since 145° dry heat produces nearly intolerable pain in one minute, and in ten minutes causes quite active hyperæmia, it is plain that the concentrated light, minus its grosser heat, is both anæsthetic and escharotic, the last in a mild degree.

In considering the former property, some allowance must be made for the effect of dessication, which, although hindered somewhat in this case by the transudation of serum, has an admitted anæsthetic effect. The latter property manifests itself in the severe blistering of the skin at elevations above the snow line and in small boats on the water in the tropics, being much severer in the early and late hours of the day, from the oblique position of the sun and the greater consequent reflection of its rays from the surface of the water.

TUBAL MOLES.

In the *Lancet*, November 12th, Dr. Bland Sutton, of London, gives an interesting illustrated article upon this subject. He says, in part:

Tubal moles differ from uterine moles in several particulars—indeed the points of distinction are such as to enable us readily to tell one from the other. The uterine mole is more or less spherical; the amniotic cavity is of fair size and occupies the centre of the mole. The embryo may, or may not, be present. Sometimes it is represented merely by an ill-shaped mass pendulous at the end of the cord. Even when the embryo can be recognized it is very misshapen, and the umbilical cord is often œdematous. A tubal mole in its early stage

the water remaining in it. The contact of the tube with the walls of the stomach is apt to excite retching. Haste should be made, therefore, to distend the organ with the spray from the atomizer. The writer uses a one- to five-per-cent. solution in any of the colorless substitutes for the crude officinal liquid petrolatum. The form of the atomizer is a matter of indifference, as almost any of the cheap nickle-tube perfume atomizers will spray an oily solution. The spray is then directed into the funnel, a piece of card-board being used to prevent a rebound of the vapor from the sides of the funnel, or the funnel may be removed and the tip of the atomizer introduced into the lumen of the tube. For a minute or two the vapor from the atomizer will meet with some resistance from the small amount of water remaining in the tube, and on auscultation a bubbling may, at times, be heard in the stomach. The vapor, like the fluid previously used, should have an alternate ingress and egress. By pinching the tube close around the tip of the atomizer the stomach may be fully distended and it should then be allowed to contract upon its gaseous contents, when the vapor and even drops of water will be expelled with considerable force from the mouth of the tube. No better proof of the fact of the entrance of the spray into the stomach can be afforded than the almost invariable statement of the patient that the peppermint can be tasted in the mouth, which it can reach only by regurgitation through the œsophagus outside the stomach-tube or through the blood circulation. After having forced the vapor into the stomach and having allowed the stomach to contract upon its gaseous contents six or seven times, it is safe to assume that the walls of the organ have become as thoroughly coated as would the pharynx or the nose after the same number of applications, barring the fact that the vapor has to follow a longer course and that the surface to be medicated is of much greater area.

The finely-divided spray of an oily solution of menthol distends the stomach symmetrically with little tendency to gravitate to the greater curvature and without straining the ligamentous and peritoneal attachments of the stomach. The vapor diffuses itself in all directions, touching almost every cell of the mucous membrane with a tiny oil globule holding in solution a small amount of menthol. In the aggregate, the clean surface of the stomach is coated with a medicated film of inert mineral oil. This film forms an antiseptic dressing for the mucous membrane, has little if any irritant action aside from the excitation of the menthol, and is, for the most part, brushed off by the first food which enters the stomach. The action of the menthol must be almost entirely local, for the oily solution, though strong enough to act on the mucous membrane, is not used in sufficient volume to make the constitutional action of menthol noticeable.

The value of the menthol spray has been so thoroughly demonstrated in the treatment of more accessible mucous membranes that it seems pardonable to report this new use of it without waiting for a longer series of cases or a greater lapse of time to speak more emphatically in favor of its local action in the stomach. The nine cases reported (and several others not mentioned in this paper) seem to show that the use of the menthol spray in cases of atony or catarrh of the stomach is followed by at least temporary benefit.

The use of other remedies in spray form is suggested.

"INFANTILE RESPIRATORY SPASM."

In a paper recently read before the Edinburgh Medico-Chirurgical Society, Dr. John Thomson gave a short account of five cases that had come under his observation in which this curious and interesting condition had existed. It is

also known as congenital laryngeal stridor, or infantile laryngeal spasm, and Dr. Gee has described a similar, although somewhat different, condition under the term "respiratory croaking." Of Dr. Thomson's five cases, three were boys and two were girls, whereas in all previously recorded instances where the sex is mentioned it seems to have been confined to girls, and the condition is often said to occur only in female children. As regards family history and general health, there is nothing of very great significance, except that in four of the cases more or less indigestion was present. In none of the patients was rickets apparent when the children were first seen, but it appeared later in those longest observed. There was no sign of congenital syphilis in any of the cases, and intellectual development seemed perfectly good. The onset of the stridor was noticed in three instances immediately after birth, in one infant it was not observed until a week, and in the other a fortnight later. As regards the course of the malady, Dr. Thomson says that in very severe cases the stridor goes on increasing in loudness during the first two or three months and then tends to subside spontaneously, and as improvement goes on the intervals become longer and the sound less loud, that accompanying inspiration, the crowing sound, disappearing first, while the croaking may still be present at times. After the stridor has ceased to be heard under ordinary conditions it may appear if the child is specially excited or angry; when the stridor is present inspiration begins with a croaking noise and ends in a high-pitched crow. When the breathing is quiet the latter does not occur. Expiration is accompanied by a short croak when the stridor is loud, but at other times it is noiseless. As regards other symptoms, the indrawing of the chest wall and the episternal notch were well marked in four of the cases, but the alæ nasi did not move with the respiration, and there was a striking absence of distress or cyanosis. Variations in the intensity of the sounds were not uncommon and there were occasional intermissions, even when the condition was most constant and severe. The sounds were notably intensified by mental perturbation, more so, apparently, when the child was excited and apprehensive than when actually crying. Sleep seems to have no constant effect on the condition, and it does not cease when the tongue is depressed, nor even when the nostrils are closed, and when the child is taking the breast there still sufficient air entering the nostrils to cause loud stridor. The effect of the ailment on the general health is not great, and the most effective treatment apparently is by regulation of the diet and other general precautions. Dr. Thomson regards the condition as due to spasmodic muscular contraction, the cause of this being some central disturbance of function, and he considers it closely analogous in nature and etiology to ordinary speech stammering, both being the result of defect in the proper coördinating mechanism.—*Lancet.*

NEURASTHENIA FROM INDIGESTION.

In an article recently read before the Philadelphia County Medical Society, on urethral irritation, in which several cases are cited, Dr. Mary Putnam Jacobi says:

In a very large number of cases cerebro-spinal neurasthenias, with irritative symptoms, depend upon lithæmia, or, more precisely, upon defect in the hepatic digestion of albuminous foods.

Reasoning most plausibly, though from too few experimental data, Haig has argued that many irritative or explosive symptoms in lithæmic cases depend on a saturation of the nervous tissues with uric acid; that the nerve explosions of migraine, and also of epilepsy, are correlated with a uric acid wave, as uræmic

is spherical, but, after attaining the dimensions of a walnut, becomes ovoid. In the majority of cases the amniotic cavity occupies an excentric position. In consequence of this peculiarity the thin amnion is easily ruptured and permits the escape of the embryo. This explains the difficulty of finding the embryo in many cases where the mole has been discharged through a rent in the wall of the tube or aborted through an unclosed ostium, accompanied, as the rule is in these cases, with free hæmorrhage. The mole is easily found in the clot, but if the embryo has escaped from the amniotic cavity the chances are that it will not be recognized. It must not be imagined that because the embryo has not been found it has been dissolved by the peritoneum. On one occasion I collected all the blood and clot which I removed during an operation five weeks after the rupture of a gravid tube, and disintegrated it by a gentle stream of water. In the course of this manœuvre the embryo came to the surface, was recognized and caught. As is the case with uterine moles, the embryo sometimes dies very early, and the amniotic sac contains nothing but a small quantity of fluid. When the mole, on its escape from the tube, is discharged between the layers of the broad ligament it becomes so compressed that the embryo is found flattened out like a succulent flower firmly squeezed between the leaves of a heavy book.

It will be necessary to offer a few remarks on the recognition of a tubal mole. When a mole is found with an embryo in the amniotic cavity there cannot be any room for dispute. The same holds good for moles with an amniotic cavity, though no embryo is present. In hard firm clots in which the amniotic cavity is not recognizable, sections from the supposed mole must be prepared and examined with a microscope for chorionic villi. The presence of chorionic villi are as indicative of a mole as of the presence of an embryo. These villi are such characteristic structures that they cannot be confounded with "half-organized blood," as some writers have suggested.

It is of great importance to appreciate clearly the characters of a tubal mole, for the presence of a mole is decisive proof of pregnancy.

It will, perhaps, be useful to offer a few remarks on decidua. When a Fallopian tube becomes gravid a decidua forms in the uterus, and this curious structure has a diagnostic value. This decidua is rarely retained until the completion of gestation and thrown off during the false labor. Usually it is discharged during the early period of pregnancy in small fragments, without producing pain, or else it is expelled *en masse* with symptoms of miscarriage. When a gravid tube ruptures or aborts, the uterus becomes disturbed and the decidua is expelled. When a decidua is discharged whole it represents a cast of the uterine cavity. It is in shape pyramidal; the base corresponds to the fundus of the uterus, and at each angle there is an orifice corresponding to the uterine opening of each Fallopian tube. The apex of the pyramid is occupied by a circular hole, corresponding with the dilated internal orifice of the cervical canal. This is smooth and rounded, whilst the smaller orifices corresponding to the uterine ends of the tubes are ragged. The exterior of the decidua is shaggy, the interior smooth and dotted with many minute puncta, representing the orifices of the uterine glands.

There is little doubt that the majority of cases formerly classed as pelvic hæmatoceles are in reality the result of rupture or abortion of gravid tubes. The cases in which doubts arise are those in which women are seized with symptoms indicating internal hæmorrhage. On opening the abdomen free blood is found, often in abundance. The tube is widely dilated, perhaps ruptured, and

clots of blood hang about the fringes, yet no embryo or mole is detected. In some of these cases a decidua is discharged from the uterus. These doubtful cases will become fewer as operators become familiar with the tubal mole. The mole is so different from ordinary clot that there should be little difficulty in distinguishing it, except in cases in which it is very small.

The following is a summary of the views contained in this paper:—(1) The transformation of a tubal ovum into a mole or apoplectic ovum is beyond doubt; (2) The majority of specimens described as examples of hæmato-salpinx are gravid tubes; (3) rupture of a gravid tube and tubal abortion are the common causes of pelvic hæmatocele; (4) mesometric rupture of a gravid tube is a common cause of pelvic hæmatoma; (5) to affirm that bands of fibrin resemble chorionic villi indicates great want of histological knowledge; (6) every clot of blood found in a Fallopian tube is not a tubal mole.

Since the discovery of the tubal mole specimens of non-gravid Fallopian tubes are found to be so infrequent that in the last report of the museum of the Royal College of Surgeons I notice an account of "an unequivocal example of hæmato-salpinx." This is a fair indication of the revolution which has taken place in our knowledge of the early stages of tubal pregnancy.

ENGLAND'S PRECAUTIONS AGAINST CHOLERA.

An editorial in the *Lancet* speaks as follows against the establishment of quarantine in British ports:

We cannot help thinking that the views of those port authorities who advocate quarantine detentions, whether of two, four, or seven days, are based on a failure to apprehend one essential point which underlies our English system of cholera prevention. It is very generally thought that those who support our system of "medical inspection" as opposed to quarantine detentions pretend that the system will absolutely suffice to keep cholera out of the country. This is the reverse of that which is contended by those who are responsible for the inauguration and the future development of the system. On the contrary, they hold that whilst our port sanitary administration ought to be organized on a basis and scale sufficient to serve as a first line of defence, it is, after all, on the improved sanitary circumstances of England and Wales as a whole that we must rely to prevent the spread of imported cholera. The port districts are expected to do their best, and this best will under the English system be infinitely more efficacious than a system of quarantine detentions; but after they have done their best precisely the same is expected of the inland districts. This, too, has been the main strength of our English system of sanitary administration, for it has been largely due to the knowledge, in the face of previous epidemics of cholera, that such detentions as are suggested are impracticable under the circumstances of this country, and will hence not be attempted, that such large remunerative disbursements have been made for the purpose of public health. We think it most helpful that the defects of our ports and inland districts should be exposed, but we trust that no encouragement will, in view of the actual facts which we have to face, be given to those who advocate quarantine detentions in connection with the general traffic coming to our shores from the continent of Europe.

The Academy of Science has resolved to open an international subscription, with the object of presenting M. Pasteur, on the occasion of his 70th birthday, on December 27th, with a testimonial expressive of the esteem in which he is held by men of science throughout the world.

Recommendations of Therapeutic Agents.

Dr. Theodore Weed, of Cleveland, states that in a number of cases of rheumatic gout, himself being one of them, he has found antipyrine to be a useful agent in alleviating the pain. In his own case he divided twenty grains of antipyrine into three powders and took one every eight hours, and in forty-eight hours his pain was completely relieved. He also used it in a case of sciatica, caused by sitting for some time on a wet buggy seat. In this case he prescribed antipyrine in four grain doses, with an equal amount of quinine. In the course of two days the neuralgia had entirely subsided. He also mentions a case of bronchitis in a child of seven years where he gives three grains at night. The cough is loosened, a mild perspiration breaks out, fever is reduced, and the child awakes much refreshed. He finds that he can depend on the action of antipyrine, both as an antipyretic and as an analgesic; and he advocates the employment of antipyrine for those nervous headaches so common.

Medical Items.

A Society of Hygiene has recently been established at Rio Janeiro, owing in great measure to the efforts of Dr. Carlos Costa.

We have received a private card stating that Dr. William Osler has removed to No. 1 W. Franklin Street. Consultation hours, 3 to 5 P. M.

In a paper read at the meeting of the American Dermatological Association, Dr. Morison, of this city, reported that in his hands the injection hypodermically of Hydrargyrum Formamidatum has proven itself of great value when other remedies have failed. He says, finally: In summing up the results of my experience with these injections, I feel that I may say that in them we have a valuable addition to the list of remedies for treating syphilis; that there is no danger of abscesses following their use, since I have never seen one, after having given as many as a thousand injections; and lastly, that in obstinate cases they can frequently be relied upon to accomplish what no other treatment has accomplished.—*Transactions.*

In studying the course of crime through the world, one readily perceives how marked has been its progress. Every nation provided with the means of computing such evidence reports a steady growth of the evil, far greater than the corresponding increment in population. The proportionate difference is especially manifest of late years; it is conceded that within the past two decades crime has more than doubled. But little knowledge of figures is required to appreciate the fearful significance of this proportion. It implies that the very life of society is intimately bound up with the question of criminality, is dependent upon the arrest of this appalling, abnormal growth of vice. It implies that the measures heretofore adopted for the prevention of lawlessness have signally failed in their purpose; that, whereas created for the object of repressing crime, they have witnessed, have favored and abetted its development. And, more important still, it implies that if the evil is to be stopped, other measures must be brought to bear.—*The Summary.*

It has been said that criminals are pathological products, that by reversion to more primordial and less highly developed states they disclose a lower type of manhood; that is, they are born with such a physical organization that they are naturally inclined to an evil life. There has been an endeavor on this basis to establish a criminal type marked by certain bodily signs which would render him easily distinguishable by external evidences of inferiority and which would not alone embrace physical defects, but mental as well, so as to place his normal condition largely beyond his control. Criminal anthropology which deals with this subject, cannot, however, satisfactorily establish such a practical standard. Nevertheless, the voluntary criminal, generally speaking, either by circumstance of birth or lack of training, does not attain to the full development of the average man. Defects of mind and body are more common among them and insanity more prevalent.—Dr. Allison, Superintendent New York State Asylum for Insane Criminals, *The Summary*.

At a recent meeting of the Parliamentary Bills Committee of Great Britain, the chairmain stated (*British Medical Journal*) that he had the satisfaction of laying before the Committee specimens of Towle's chlorodyne, Freeman's chlorodyne, Dr. Collis Browne's chlorodyne, and Mrs. Winslow's soothing syrup, which were now, as they saw, all labelled "Poison." Mrs. Winslow's soothing syrup had for many years escaped the poison label which he had now the satisfaction of enforcing on it. Mothers would in future be aware of its potency, as it was prominently labelled "Poison" in red letters. Another of these medicines, "Powell's balsam of aniseed," which was very extensively advertised, was now labelled "Poison." There was another, Kay's compound essence of linseed, trade mark, "Linseed Compound," that used to have a little notice saying that it was poison in overdose, and so far was a sign, but it was now, as they saw, labelled with the proper safeguard. Mr. Ernest Hart proposed now further to communicate with the Chairman of the Pharmaceutical Society and the Public Prosecutor until he had succeeded in enforcing that every proprietary medicine containing a scheduled poison should be labelled "Poison."

Bad readings do an immense amount of harm to the young, who are given to imitate these heroes of fiction or of theatre, above all whenever the publication or drama presents vice under attractive colors. Children cannot without danger read, nor see, nor hear everything; ignorance of evil is the best safeguard of a child's morality. The automaton which is in each one of us, according to the deep observation of Pascal, is particularly inclined in childhood to reproduce acts the portrayal of which provokes emotion. That is why Plato did not believe that all sorts of fables indifferently could be told to children, and considered as detrimental to morality the tales of criminal deeds which the poets ascribed to the gods. The souls of youth, as their bodies, require a pure atmosphere, amid which they may develop in kindness, purity and courage.

The physicians and criminalists who understand the power of good and bad example would—with propriety—prohibit the press from parading in the newspapers the unhealthy outbreaks of society's moral infirmities, of its suicides and crimes; they fear, with cause, the effect of this publicity on the weak and sickly minds (for all the insane are not in the asylums), on the young men and nervous women. The details furnished upon the execution of suicides and crimes generally strike the mind and may awaken a spirit of imitation. This publicity, moreover, presents the very grave inconvenience of teaching the details of execution of criminal acts.—Translation from Louis Proal, in *The Summary*.

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SOME MINOR THERAPEUTIC USES OF THE GALVANIC CURRENT.*

BY A. K. BOND, M. D.,

Lecturer on Diseases of Children and Dermatology, Baltimore Medical College.

Gentlemen:—As a member of the Section on Therapeutics of this Faculty, I have felt it my duty to contribute some paper upon Therapeutics at the present session, even though my communication should seem trivial in comparison with the more studied and elaborate papers presented by other members.

If only I shall have aroused in one or two of my hearers a determination to add to their therapeutic armamentarium the hitherto untried virtues of galvanism, and shall have thrown some light on the management of some of the less important, and too often quite neglected, ailments of humanity, I shall rest content. For I believe that attention to minor points of therapeutics, which are apt to be overlooked in the physician's daily contest with grave diseases, is a very important element in the acquisition and retention of patients and in the relief of physical distress.

My practical interest in the therapeutic use of galvanism began about a year and a half ago, when I first felt justified in investing in the galvanic battery on which I had set my desires some time before. I refer to the 50-cell chloride of silver dry battery manufactured in Baltimore.

*Read before the Medical and Chirurgical Faculty of Maryland, at Easton, November 16th, 1892.

My experience in hospital with the old-fashioned liquid batteries was that they were sloppy and dirty, uncertain in their action and generally at the instrument-maker's undergoing repairs at such times as you especially wanted to use them. The dry-cell battery in my possession, with which my experiments have been made, is absolutely clean, always ready for action, portable, and constant in force, and appears to be in just as good condition as regards current as when I first bought it. It is very expensive, but needs no repairs, and can be refilled, after a number of years' use, at small cost.

I am not employed to advertise batteries, but I believe that one has a right to speak well of a good article, even if it is manufactured in his own city.

SIMPLE GALVANIZATION.

In speaking of the therapeutics of galvanism we begin naturally with the simple passage of the steady current through the tissues of the body by means of sponge electrodes placed on the skin. This is a very extensive theme and I cannot enter fully upon it now. A very hot dispute has been raised upon the question whether the form of battery which I have named is as good for the treatment of deep-seated nerve-lesions as a battery of a few large cells. I am quite unable to decide this question. When muscular contraction is sought, the 50-cell battery will give about all the contraction that the patient can stand if the poles are rightly placed. I have used this method chiefly for the relief of pain, and in many cases it has given excellent results. On one occasion a lady, ill with influenza, whose headache and pains in the upper portion of the body had yielded to phenacetin, antipyrin, etc., but who still suffered from intolerable aching in the lower limbs, especially about the knees, which was not soothed by hot applications, obtained speedy and permanent relief when I applied a 40-cell current, passing it first from the hip to the ankle and then from one ankle to the other.

In a case of nervous cough, the cough ceased soon after the application of a strong current, one pole being on the back of the neck, the other on the larynx. A dressmaker who had suffered for a week or more from a stiff neck, which compelled her to carry her head on one side, and in addition to its painfulness, greatly interfered with her work, applied to me for relief. I passed a steady current through the affected parts for about fifteen minutes, straightening up and moving the patient's head as the current passed. No other remedy was used. The pain was at once relieved and voluntary motion so restored that no further treatment was necessary.

CATAPHORESIS.

The passage of liquids (and apparently powdered solids) through the skin or other tissues is, under certain circumstances, greatly favored by the electric current. This phenomenon is called "cataphoresis." My attention was drawn to it recently by an article from the pen of Dr. Hunter McGuire, which was epitomized by me in the editorial columns of the MARYLAND MEDICAL JOURNAL, October 21, 1891. Dr. McGuire reported seven cases in which he had applied

tincture of iodine in this way to goitres, with considerable benefit; and stated that he intended to use it in hypertrophy of the tonsils. About the same time I made a very interesting observation on a patient. She consulted me for severe neuralgia or myalgia of the right shoulder, which she had treated without relief by the application of red pepper on cotton batting. I removed this application and passed a current of some thirty cells through the part. An intense burning sensation resulted, which continued half a day, but was borne patiently by the lady, as the pain had been relieved. In reflecting upon the meaning of this peculiar burning sensation, which was not associated with any redness of the surface, I was forced to the conclusion that the red pepper, left behind by the cotton, had been driven by the current to some depth into the tissues of the skin. I have, since, frequently applied chloroform to the skin in this way, and it has seemed to me that the relief to pain was greater than by the passage of the simple current. In making the application, the drug to be applied by cataphoresis should be poured on the sponge of the positive electrode, or on a bit of absorbent cotton attached to the positive electrode. This electrode is now placed on the skin over the painful region, while the sponge of the negative electrode, moistened with water, is pressed upon some other part of the surface of the body. Ten or more cells are used. At the point where the positive electrode rests, a burning sensation will soon be felt; and when chloroform is used this burning will be intensified, and a blister or inflammation of the skin may result if it is applied too long in one place. The whole painful area may be treated in this way, with immediate, and frequently permanent, relief to the pain. I have used this cataphoretic application of chloroform in many cases with marked benefit, although in some instances it failed. I shall refer later, in speaking of the destruction of hairs, to the benefits which I have derived from the application of cocaine to the skin by cataphoresis, complete anæsthesia of the skin being obtainable by its use—so that a needle is not felt when driven into the skin. During the past week, in preparing this paper, I have learned that another had before me made the same observations. The *Annual of the Universal Medical Sciences*, 1892, states that Peterson has employed by cataphoresis "helleborin, strychnine, aconitia, chloroform and cocaine (10 to 20 per cent.). Three or four drops of a one per cent. solution of helleborin on the positive electrode have produced a deeper and more lasting local anæsthesia than cocaine, without constitutional effects. For rheumatic and gouty swellings, solutions of the chloride, benzoate or citrate of lithium should be employed by cataphoresis. Among mercurial remedies the imidosuccinate and bichloride are well adapted for such use."

Morton (*Ibid*) asserts that the action of the drug may be limited to the tissues of a part for as long a time as desired, if the blood be first expelled from the part by means of an elastic bandage, or (on the fingers) of a rubber ring. He calls this "anæmic cataphoresis." Fraser and Company prepare medicated and unmedicated plasters for "anæmic cataphoresis."

STYPTIC INFLUENCE.

The application of a needle, attached to the positive pole of the battery, has a very interesting styptic action upon bleeding tissues. If bleeding occurs from the puncture of minute venules in the electric destruction of hairs, it may be immediately stanched by reversing the current and making the needle positive instead of negative. This is a fact of much importance in the destruction of vascular tumors by the electric needle. I have tried it with success in tissue-hæmorrhage only, in which it is very satisfactory. Whether it will control hæmorrhage from small arteries, or not, I do not know. I suspect that larger metal electrodes, attached to the positive pole, would have a similar styptic influence with a strong current. I believe that this has been proven useful in uterine hæmorrhage; but, whether through its local styptic effect on the bleeding tissues or not, I cannot tell.

THE ELECTRIC KNIFE.

I have, within a few days, opened a small abscess with a knife attached to the negative pole of a twelve- or twenty-cell battery. My purpose was to secure an incision with cauterized walls, which would not act as absorbent surfaces for the septic action of the abscess-matter. I secured a cauterized incision. The patient (a medical student) said that the pain which he had expected from the incision was absent, and seemed to be replaced by the slight burning sensation which attended the passage of the current. He also remarked upon the unexpected facility with which the knife penetrated the tissues.

This influence of the current in drawing the electrode (as it were) into the tissues, is familiar to operators with the electric needle, for as soon as the current passes, the needle seems to pass almost of its own accord into the skin. This phenomenon deserves further study and wider application in surgery, so that its value and limitations may be learned. The corrosive influence upon the knife is too slight for consideration, if indeed any corrosion takes place during a rapid incision. I do not know exactly what effect will attend incisions with a knife attached to the positive pole. Some lessening of pain would perhaps be noted through the soothing influence of the positive pole. Very probably, incisions almost free from pain may be made by the negative knife, and such incisions might be made almost bloodless by reversing the current immediately after incision, and making the knife positive and styptic.

THE ELECTRIC SOUND.

The facility with which stricture or stenosis may be resolved by means of insulated metal sounds attached to the *negative* pole of a battery, the positive sponge electrode being placed anywhere on the skin, is well known, although many observers have denied the permanency of the dilatation. I have no experience to add to those of former writers. I believe, however, that I have obtained therapeutic results of value from the use of a sound attached to the *positive* pole of a battery of from 12 to 15 cells.

A patient came to me this summer for relief from an acute nasal catarrh, occurring repeatedly, and being rendered very disagreeable by temporary occlusions of the nostrils, paroxysms of sneezing, and profuse discharge of secretions requiring continual sopping up of the fluid. It was not produced by flower-pollen; but seemed to be a local congestion or œdema through nervous reflex in a very sensitive woman. The application of cocaine would give temporary relief, but the patient dreaded the cocaine habit. Sprays, and anodyne and astringent washes increased the irritation. Having a sound with insulated aluminium bulb about as large as the largest which can pass through the normal nasal canal, it occurred to me that the local application of galvanism might be of benefit. I therefore slowly introduced the sound, attached to the positive pole. By gentle pressure I carried its bulb back into the pharynx, finding some very sensitive points far back on the floor of the nares. At these points the bulb was allowed to rest for a while. By moving it forward and backward the nasal canal was opened widely; the discharge from the anterior nares ceased, and for 24 hours the patient was comfortable. Daily applications were made, each time with great benefit, until the irritation and congestion of the parts ceased. I do not think severe cauterizations would have been justifiable in this particular case. On another patient I used the insulated bulb to relax nasal spasm and sensitiveness, and immediately upon its withdrawal passed the hard gum Eustachian catheter. It was very difficult, sometimes impossible, to pass the catheter by itself without the use of the current. I suggested, in reporting this case, that metal Eustachian catheters, or catheters with insulated metal tips attached to the positive pole, might be readily passed in certain difficult cases, saving much suffering on the part of the patient. Exactly how the resistance is overcome in these cases I do not know. It may be by partial local anæsthesia or by chemical action on the tissues, or by both. It would be worth while to try the attachment of the metal instrument to the positive pole of a battery of 10 or 15 cells in the difficult and dangerous soundings of the urethras of old men, which so often baffle the practitioner. The positive bulb gives little or no pain with this number of cells, while the negative bulb burns very unpleasantly.

CAUTERIZATION WITH THE ELECTRIC NEEDLE.

If a moist sponge, attached to the positive pole of a galvanic battery, be held in the hand, and a needle be attached to the negative pole, the needle will act like a caustic upon the skin or any other soft tissue of the body with which it is brought into contact. The caustic action is due, probably, not to any change in the needle, but to the electricity passing between it and the tissues. The caustic influence seems to be due to the concentration of the current upon a small area; if a large enough battery were used, I do not doubt that a bulb of considerable size might be endowed with caustic properties. With the electric needle, a battery of from five to fifteen of the chloride of silver cells is sufficient I have used the needle in this way for several purposes.

First. On the surface of unhealthy ulcers of small size. In those most painful and very persistent aphthous sores which so frequently appear upon the mouth-walls, lips and tongue of certain individuals and remain for a week or more, rendering life a burden, I have gotten most excellent results from the application of the electric needle. Wherever the needle touches, the tissues are decomposed into a white froth, and the whole base of the ulcer and even the tissues underlying it may thus be accurately and completely destroyed, leaving a clean and healthy wound. It appears that the intense pain and sensitiveness to motion, which accompanies these sores, is dependent on a disease-process going on in the tissues at the base, which (sometimes in the form of a hard core) are tightly bound down to the underlying parts. As soon as the slight soreness from the action of the needle has passed away, the ulcer heals up painlessly like a healthy wound. The application of pure carbolic acid and other caustics will likewise ease the pain; but it produces more irritation of the surrounding parts, and the ulcer is apt to become painful again after a time, as the caustic may not penetrate the hard core. The pain which attends the application of the needle may be partly or wholly prevented by the application of cocaine ten or fifteen minutes before operation.

I think that the needle will gain favor as a caustic for chancroids, small epitheliomatous ulcers, and other unhealthy sores of small size. At least, it deserves a fair trial; for although it requires time to go over a surface of any size, its action is absolutely controllable, and healthy or diseased tissue may be destroyed at will, without fear of inflammation, suppuration, or the production of a larger wound than was intended.

Second. For the destruction of small growths upon the skin and mucous membrane. If a wart or other small tumor of the skin be transfixed through its base in several directions by the electric needle, so that its tissues are cauterized by the current, as is shown by the appearance of froth about the needle, it will in a few days shrivel into a crust and drop off, leaving a quickly-healing surface. Vascular tumors may be treated in the same way. There is no danger of a hæmorrhage, since the reversal of the current makes the needle (as I have already stated) strongly styptic. A case of some interest occurs to me in this connection. A middle-aged woman came to me for the removal of a tumor, the size of a large pea, which had recently appeared on the mucous surface of the lower lip and grown rapidly. At times it bled profusely, on the slightest touch from its broad base and from an abraded spot on its smooth, rounded distal surface. I transfixed its base in several directions with the electric needle, making the needle first the negative pole and caustic, then the positive pole and styptic. There was no bleeding of moment. I then tied a silk ligature tightly about its base. At a visit four days later the tumor had fallen off, leaving a small, quickly-healing sore. If this case had been treated by ligature without the needle, I might have had at once, or afterwards, a very troublesome hæmorrhage from the sensitive base.

Third. For the destruction of hairs. In the performance of this delicate operation the electric needle, attached to the negative pole of a small battery, is passed down the hair canal to the papilla from which the hair grows, and this papilla is destroyed by cauterization. The caustic action affects the whole canal and leaves a clean wound tract, which heals, usually without suppuration, within a few days. The essential point is the destruction of the papilla. If this is not accomplished the hair will grow again. My short experience with the destruction of hairs by use of the electric needle teaches me that it is by no means as easy as one might suppose. Yet there are reasons why its intricacies should be mastered by the ambitious physician who is not born with the silver spoon of a large and lucrative practice in his mouth. It may be learned readily by any physician who has ordinary ability and a large supply of perseverance; patients can be found almost everywhere able to pay for it; and, lastly, the public has a right to demand that the medical profession shall not leave the matter wholly in the hands of itinerant advertising practitioners, but shall itself be ready to furnish the best known remedy for the disfiguring abnormal hair-growths which, though apparently trivial, overwhelm with shame and blight the life of many a cultured and otherwise happy woman. It will be a welcome day for womanhood when some other easier method shall be discovered for the removal of these blemishes, but as far as I can learn the washes and powders heretofore used for this purpose are all liable to inflict permanent injury upon the skin.

In undertaking the removal of hairs with the needle, the operator should remember that the hairs differ greatly as to the location of their roots. Some are placed just beneath the surface, while others spring from the subcutaneous tissues and wind about for perhaps half an inch through the skin before they come to the surface. For the superficial hairs a common fine sewing-needle is sufficient, with six or eight cells of the battery. For the deep-seated winding hairs a flexible needle is necessary, with ten or fifteen cells. The details of the operation may be learned from modern text-books on dermatology; I desire here simply to note a few points gained from personal experience.

The pain attending the removal of hairs from the upper lip, especially at the point where the nasal septum joins the lip, is in some persons exquisite, bringing tears into the eyes. In order to prevent such suffering I am in the habit of driving strong solutions of cocaine into the part by cataphoresis (as explained above) before operation. For this purpose a bit of absorbent cotton, soaked in a solution of hydrochlorate of cocaine, 10 or 20 grains to the ounce, is attached to the positive pole of the battery and pressed upon the skin, and a current from between ten and twenty cells is passed through it. After ten minutes have elapsed the part is much less sensitive to pain; and after reducing the number of battery cells and reversing the current, the operator may begin cauterization of the hair-roots.

My experience teaches me that superficially seated hairs, whether large or small, may be easily destroyed by a pointed, stiff electric needle thrust straight

down along their shafts. We may calculate with reasonable certainty that they have been permanently destroyed by the current if they almost drop out, of their own accord, when grasped by the forceps. The operation for removal of the deep-seated hairs with tortuous root-shafts, which are most abundant beneath the lower jaw, is a very much more difficult and tedious undertaking. The thrusting in of a pointed, straight needle along the shaft does no good whatever, as the needle simply makes for itself a false passage and cauterizes the tissues in its path; and although we may pull out the hair (as we might if no current had been used), it will promptly grow again.

What we need for the destruction of these hairs is an unpointed, flexible needle, which will not readily make false passages, but will follow the windings of the hair follicle. If it is expensive it must resist chemical action, which soon corrodes and roughens the common sewing needles; they, however, can be cheaply replaced. The Hardaway needles, made by the A. M. Leslie Company, of St. Louis, is highly recommended as possessing these properties. Having none of these at hand, I tried platinum wire. It is flexible enough, but is too thick as found in the market, and it breaks easily under the pressure of the binding screw. Of late I have used bits of pure gold wire, drawn by a watchmaker down to the next-to-finest hole of his drawing-steel. It is extremely cheap; is flexible enough to follow the follicle, yet surprisingly tough; and it may be sharpened, if desired, by scraping with a pen-knife, or may be tipped with a tiny bulb by holding it in an alcohol flame.

I find that in some cases the tortuous hair is not loosened until the needle, inserted at its side and penetrating to the bottom of its follicle, has been carried completely around the hair shaft, cauterizing the walls on every side and destroying the bulb and papilla at the bottom.

In treating a very large deep-seated hair, the needle or wire must not be too fine. The skin under the lower jaw is not very sensitive, and I have not found cocaine applications necessary in this region.

There is a belief abroad in the profession that hairs destroyed by cauterization with the electric needle grow again, but I cannot find, either in my own experience or in works on dermatology, any proof of such recurrence. The apparent failures of the method are probably due, first, to the failure of the operator to reach the hair papilla; and second, as I suspect, to some stimulating influence exerted upon the adjacent skin by the current under which a certain limited number of small hairs are excited to more active growth. After a few sittings this influence seems to have exhausted its force or to find no more hairs that can grow to a large size.

I have not found it necessary to employ any apparatus for the measuring of the electric current used. The number of battery cells brought into action and the effect of the current upon the tissues are sufficient indexes of its strength.

To recapitulate, the activities of the galvanic current to which I have called attention are as follows:

At the *negative* pole—caustic action, whether with the knife or needle; and a tendency to allow easy penetration of the tissues by the knife or needle.

At the *positive* pole—cataphoresis; relaxation of obstructions; styptic powers.

Common to *both* poles—the soothing force exerted in general galvanization by sponge electrodes upon painful affections.

420 W. Biddle Street.

A CONTRIBUTION TO THE LITERATURE OF FOREIGN BODIES IN SURGERY.*

BY A. C. POLE, M. D.,

Professor of Anatomy in the Baltimore Medical College.

On September 7th, 1885, Mr. G. W., who was assaulted by a crowd of roughs, presented himself at my office with an incised wound between the anterior and upper part of the auricle and the temporal bone. The wound was examined and cleaned, and neither seeing nor suspecting any foreign body, I stitched and dressed it, and after a few days found that it had healed by primary union. I did not again see my patient professionally for about two years, when he called at my office, complaining of having a discharge from his ear. He stated that in dressing his ear or removing the discharge, which he was faithful in doing, he had detected a piece of bone in the canal.

I examined his ear carefully through a speculum auris by reflected light and found the auditory canal nearly occluded by a fungous-looking growth, which, when touched with a probe, was very sensitive and bled easily.

By introducing the probe behind this fleshy mass I felt what seemed to be a projection of uncovered bone, which I supposed was the result of an injury received.

The patient was very anxious to have the "bone" removed, and was willing to submit to any opration tending thereto. Fearing that more harm than benefit might result from an attempt to drill or gouge it away, I tried to dissuade him from submitting to such an operation.

After seeing him on several occasions at long intervals and finding him still very anxious to have something done, I referred him to an eminent specialist, who attempted at several sittings to remove the "bone," but without avail.

Disheartened by the fruitless attempts of his physicians to remove the offending body, he wearily waited for quite a long period for nature to come to his relief.

He again applied to me for assistance and expressed his willingness to submit to any operation, however dangerous, if thereby he might be rid of this "thorn in the flesh."

Again I examined the ear and found that whatever the foreign body was, it seemed to be lowering somewhat in the auditory canal. By touching with the probe it seemed to be slightly movable.

*Read before the Clinical Society of Maryland, November 18, 1892.

Thinking that nature was indeed coming to his rescue by liberating it from its attachment, I advised him to patiently wait a while longer. After a few weeks he again presented himself for examination.

The investigation of the ear at this time revealed a black projecting point of slate-like appearance, directed upwards and forwards toward the anterior wall of the auditory canal. By pressing back the fleshy substance I could uncover a portion of its surface, which I attempted to scratch with an instrument, but could not make any impression upon it.

I introduced my forceps, and seizing hold of the point, made gentle traction on it, which caused the patient great pain, but which seemed to move the body slightly.

Realizing now for the first time that I had a foreign body which had entered from without to deal with, and being still ignorant of its character and point of attachment, I advised him to wait for a week or two longer, hoping that nature would lower it still more, as she had apparently done since my previous examination. At the next examination I found that a larger part of the object was exposed; and upon a close inspection I thought I could detect a part of a broken blade of a pen knife.

Slight traction was again tried, but on account of the great pain experienced I desisted, but determined and proposed that he be anæsthetized and have the body removed, to which proposition he willingly assented.

On September 22nd, 1892, with the assistance of my friends, Dr. Charles E. Sadtler, who administered chloroform, and Dr. Eugene L. Crutchfield, I removed through the external auditory meatus a piece of dagger blade measuring $\frac{31}{32}$ of an inch in length, the point and blade having entered the posterior wall of the canal, and penetrated into the mastoid cells to the depth of about $\frac{5}{8}$ of an inch. The piece of blade had been in this position for *seven* years.

Wishing to verify the truth of the theory advanced, I secured a skull and a dagger, and placing the point against the posterior wall of the auditory canal in about the direction from which the piece of blade was withdrawn I caused it to penetrate into the mastoid cells to the extent of the *piece* of blade, and in this position it presented about the same amount of surface as was seen through the ear speculum. In this skull with the dagger in position you will feel through the foramen magnum the point in the lateral sinus.

I do not wish to convey the idea that the dagger in the patient's head penetrated into the lateral sinus, as the experiment on the skull exhibited would seem to indicate, but that the blade entered the mastoid cells in close proximity to the lateral sinus, as shown in the diagram.

At the time of this report, which is two and a half months since the operation, the patient is quite well and has not had any bad symptons resulting; he has been relieved entirely of severe neuralgic pains from which he suffered for several years past.

2038 Madison Avenue.

URETHRAL IRRITATION.†

BY MARY PUTNAM JACOBI, M. D., NEW YORK CITY.

The causes of vesical and urethral irritation in women are both numerous and diverse. Gynæcologists constantly refer to the irritation which accompanies uterine lesions—either inflammations or displacements. Dr. Howard A. Kelly has called attention to the tenesmus and frequent micturition which may be excited by lesions of the ureters, and such tenesmus may, for a certain time, be the most salient symptom of a renal calculus. On the other hand, the distinguished Philadelphian gynecologist, Dr. Wm. Goodell, has truly said that "a nervous bladder is one of the earliest symptoms of a nervous brain; for nervousness means a deficient control of the higher nerve centres over the lower ones; the vesical irritability indicates a lack of brain-control." The following case excellently illustrates this remark:

It was that of an unmarried woman, about twenty-five years old, of a highly nervous temperament. A year previous to consultation she had, together with a sister, opened an office for type-writing. The business responsibility was unfamiliar, the work often heavy, and the patient had become anxious, worried, and excited over it. She did not, however, complain but of one symptom, namely, a frequent vesical tenesmus, recurring night and day. The passage of urine was free, but preceded and followed by an unbearable distress, apparently situated in the neck of the bladder. The urine was entirely normal in every respect, free from albumin, sugar, oxalates, or other sediment, inorganic or organic. The urethra was normal, and the bladder could be explored by the sound without causing any pain. There was no uterine disease. I should add that there were no definite hysterical symptoms, unless the irritability of the bladder be reckoned as hysterical. The patient was entirely cured by local faradization—one electrode being placed over the lumbar spine, the other over the bladder. A few applications were first made at my office, and immediately followed by diminution in the irritability of the bladder, and in the tenesmus. Then the patient procured a faradic battery for herself, and applied the current for about twenty minutes every night. Relief was speedily obtained, and a complete cure effected in a few weeks.

My recollection of the details of this case is incomplete, as it was observed by me a good many years ago, and I have not full notes. If the frequent and spasmodic contraction of the bladder be due to an over-excitation of the nerve centres of the lumbar spinal cord, and if this over-excitation be due to loss of cerebral inhibition, it is difficult to understand why the local application of the stimulating form of the electric current should have had so positively curative an effect. The explanation may be approximately referred to the general action of faradic electricity on hysterical peripheric neuroses—action which may almost be

†Read before the Philadelphia County Medical Society, November 9, 1892.

called specific—since it is exerted with success in all three forms, namely, hysterical paralyses, hysterical cramps, and hysterical paræsthesias.

Another case was that of a markedly hysterical woman, aged fifty years, and who had passed the menopause, but who was subject to profound analgesia of the lower extremities, so that a pin could be plunged into the flesh and buried to its head without causing the least pain. This patient was subject occasionally to acute attacks of vesical irritability, associated with great general nervousness and depression of spirits. Such an attack was promptly dissipated by the injection into the bladder of two grains of cocaine dissolved in an ounce of water.

A third case was chiefly remarkable for the long duration of a single symptom for the limited extent of its causal lesion, and for the final success of the treatment. The patient was a West Indian creole lady, between fifty and sixty years old, a widow, who had never had any children, and had never suffered any uterine disease. She was remarkably short, had an old-standing lumbar scoliosis, and suffered often from the muscular pains of lithæmic indigestion. She consulted me for an annoying and constant sense of pressure at the neck of the bladder, or rather more externally, at the urethra, attended with a moderate frequency of micturition, but no alteration of the urine. Just before and after micturition the sense of pressure increased and became more painful. Fifteen years previous, to relieve this same symptom, the urethra had been forcibly dilated by Dr. Marion Sims, but the patient insisted that she had not been at all benefited by the operation.

No spasm and but little pain was caused by the introduction of the catheter; and dilatation of the urethra with an ordinary urethral speculum failed to reveal anything abnormal. I tried several plans of treatment upon the case, which were all quite unsuccessful, and the patient finally ceased attendance. About five years later, very much to my surprise, she returned with exactly the same complaint. On this occasion, thinking that this peculiar and limited morbid sensation might be a pure neurosis, I applied faradic electricity by means of a double electrode inserted into the urethra and just within the bladder. This treatment at once greatly relieved the patient, and the relief persisted for twenty-four hours, when the distress returned. Repetition of the local electrization had the same effect, and the patient was so much more improved by this treatment than by any other which had been tried, that she persisted in it for several weeks. By that time she considered herself very decidedly improved, but not yet well. I then had an endoscopic examination made, and found that the mucous membrane of the bladder immediately surrounding the urethral orifice was swollen into a ring. The surface of the ring was moderately reddened. It seemed as if this protruding localized hypertrophy of the vesical mucosa had formed during efforts at bladder expulsion made in former years against some obstruction—very possibly a spasmodic contraction of the neck of the bladder in consequence of a fissure. The faradic electricity had relieved by determining retraction of the submucous cellular tissue. It seemed probable that the local application of a strong astringent

would effect a more permanent shrinkage of the swollen mucosa. Accordingly, applications were made of solution of nitrate of silver—five grains to the ounce—by means of an instrument that permitted the application to be made exclusively to the affected locality. The result was immediately beneficial, and a few similar applications, made twice a week, succeeded in entirely curing this troublesome symptom, which had been annoying the patient for twenty years.

My fourth case seems to me of unusual interest, both on account of its medical history and of the physiological doctrine it illustrates. The patient is a woman of thirty-five years of age, who for many years had been overworked and underpaid in responsible business employments. Eight years ago her health began to fail, and in particular she began to suffer from two symptoms—severe spasmodic dysmenorrhœa and a distressing, burning sensation at the urethra. This was at first said to be constant, but inquiry showed that the patient suffered little from it while lying in bed, but intolerably if she attempted to walk, so that she soon became unable to walk but a block or two. She consulted a prominent gynæcologist, who treated her locally for three months, then advised her to enter the Woman's Hospital. She remained for some time in one service, and at length the surgeon declared he could do nothing more for her unless she would submit to the operation of an artificial vesico-vaginal fistula. Refusing this, she entered another service in the same hospital, and here Emmet's button-hole operation on the urethra was proposed and performed. The patient, however, did not benefit in the least from these various manipulations, but rather grew steadily worse, According to her statement the most careful exploration was repeatedly made for any pelvic lesion adjacent to the bladder which could explain the persistent distress, but nothing definite was ever found.

After ten month's residence at the hospital the patient left it, rather worse than when she entered. She then went to England and consulted Dr. Keith, who, after a careful examination, advised her to desist from all further treatment. She followed this advice, and attempted to resume work, but her strength continued to deteriorate, and she finally was compelled to give up her work again, and remained a wretched invalid.

When the patient consulted me she was a thin, pale anæmic woman, quiet and rather slow of speech—rather unusually free from the excitability and mobility which so often characterizes hysterical patients. Examination of her blood found 70 per cent. of hæmoglobin, and 1,960,000 blood corpuscles to the cubic millimetre. There was a continuous venous hum at the jugular.

The patellar tendon reflexes were normal. The subjective symptoms were: A constant sense of fatigue, mental and physical, rendering all exertion impossible; this associated with a sense of mental confusion and imperfect memory; distress, rather than pain, in the back of the head; profuse sweating at night; tenderness on pressure at Charcot's point, but on the right side; the skin over the hypogastrium and thighs moderately hyperæsthetic to touch, and extremely so to faradic electricity. There was a constant burning pain at the urethra, not

at all aggravated by micturition, but greatly by walking. A distance of one or two blocks could be traversed with comparative ease, but then the burning pain became intense; a bearing-down sensation in hips and hypogastrium was added, and a heaviness extending down the thighs.

At menstruation the patient suffered intensely for several days, but during the pre-menstrual week she usually felt pretty well, at all events much better than at any other time. This fact contrasted emphatically with the pre-menstrual pains which almost invariably characterize ovarian disease. Again, micturition was neither painful nor frequent, and was unaccompanied by tenesmus. A local examination found the uterus perfectly healthy; nothing abnormal discoverable in the pelvis except tenderness upon pressure in the region of the left ovary. The latter, however, was not sufficiently accessible to be exactly defined.

The urethra remained deformed by the partial failure of the union attempted after the button-hole operation. A catheter passed into the bladder caused no pain until it reached the neck of the bladder—then a spasm occurred, moderate in intensity, but causing great pain. The spasm was easily overcome, and within the bladder the instrument caused no pain. The urine was normal in every respect. The patient had discovered for herself that the ingestion of large quantities of hot water—increasing the quantity of urine—diminished somewhat the urethral paræsthesia. If for any reason the urine became scanty, the burning became intense. The negative result of the local examination was entirely in accordance with that of the repeated explorations which had already been made by distinguished surgeons. In view of it, and of all the circumstances of the case, I myself made the diagnosis of a severe cerebro-spinal neurasthenia, of which the urethral burning, the ovaralgia, and the dysmenorrhœa, were concomitant symptoms. They were, so I argued, symptoms projected on the periphery from a brain so badly nourished as to be the prey of sensory hallucinations, generated in its lower visceral centres. The history of the case seemed to indicate that local manipulation of the bladder tended to increase, rather than diminish, the subjective hyperæsthesia. The aggravation of the paræsthesia by walking, the relief afforded by recumbency, seemed to me to depend on the facile exhaustion of the centres in the lumbar cord, with their double relations to the innervation of locomotion, and to that of the pelvic viscera. It did not, as evidently had been supposed, argue a coarse lesion of these viscera, which may be aggravated by pressure; rather a vasomotor neurosis due to loss of spinal control when the lumbar cord centres became exhausted.

The case is still under observation and the symptoms oscillate, although with, on the whole, a steady improvement in the condition of the patient. She is kept in bed the greater part of the day, on a diet of milk, baked apples, and a little rice; takes a steam leg-bath followed by cold sponging, minute doses of iron with maltine. Sleep is greatly improved, the mental depression lessened, the urethral burning reduced to a minimum, only occasionally aggravated; such an aggravation occurred on a cold, damp day; but on the next, a bright and clear day, the

patient again felt a great deal better—nevertheless she was suffering more than usual from the occipital pain. This latter was entirely dissipated by an application of static electricity below the occiput. The same application was then made along the spinal column, and although for two minutes the patient was greatly fatigued, she then experienced an agreeable and warm glow and sensation of prickling all over her body; and coincidently, what degree of urethral distress and ovaralgia was for the moment persisting, entirely disappeared.

Throughout that day and the next these two symptoms remained entirely absent, but the occipital headache returned on the second day, to again disappear on the third.

The absence of local pelvic lesions in this case might seem to render it inappropriate for presentation at this meeting; but I have thought it interesting because the existence of local symptoms seems to have been sufficient to convince so many distinguished physicians that such lesions must exist, even though they failed to discover them. Yet it is a general law for sensory symptoms that any one may be due to one of three conditions: There may be a structural lesion at the point to which the sensation is referred. There may be a lesion at a distant or adjacent point from which nerve irritation is irradiated to the point of sensation. Finally, there may be a functional disturbance of the brain nowise representing the part, which disturbance is expressed by the morbid sensation referred to the periphery. On this account there should not have been any difficulty in regarding this urethral symptom as an expression of central nervous disturbance, from the moment that careful examination had failed to detect any local lesion of the bladder, urethra, or adjacent pelvic organs. Yet the presumption in regard to such lesions was so great that when they were not found, they were almost invented; and when prolonged surgical treatment only left the patient in a worse condition than at first, she was given up as incurable, because her parts refused to adjust themselves to a preconceived and erroneous theory.

Society Reports.

TRANSACTIONS OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

SECOND ANNUAL MEETING, HELD IN NEW YORK, OCTOBER 4, 5 AND 6, 1892.

FIRST DAY, OCTOBER 4, MORNING SESSION.

The Association was called to order by the President, who then delivered his address on "Electricity and Medical Art and Science." Seldom, he said, had a branch of science requiring so much intelligence been so sedulously relegated to the incompetent, with exceptions the more brilliant by their isolation. Among the reasons for the present backward position of electro-therapeutics are the difficulties of comprehending the nature of electricity, traditional adherence to drugs in the treatment of disease, and skepticism as to the value of other thera-

peutic measures, a natural contempt for the ignorant methods pursued by charlatans, who were among the first to make much use of this agent in medicine,and the ignorance of the public, who regard electricity as a great "cure-all." At present, the electrical engineers are beginning to invade the realm of biology, and what is more important, medical men are turning their attention to the physics of electricity. We build our faith upon the known and remarkable action of this agent upon living tissues, viz: The excitation of living protoplasm; electrolysis, without which there would be no conduction; cataphoresis, by which the fluids of the human body are moved by the flow of the current from the positive to the negative pole; and the vaso-motor effects. Electrolysis, chemically, and cataphoresis, mechanically, alter the amount and distribution of the salts necessary to the proper nutrition and function of the various parts of the living organism. Electrical action in the human body to a great extent becomes a chemical process, and as it is there confronted with the ordinary chemical processes of the living organism, it may be said that much of electro-therapeutics is chemistry against or in conjunction with chemistry.

The next in order was the report of the committee on standard coils. This committee has been unable, as yet, to formulate a report, but the members, Drs. Morton, Goelet, Hutchinson and Massey, expressed their individual opinions on this subject.

Dr. Goelet, of New York, had found the manufacturers, with the exception of the Chloride of Silver Dry Cell Company and the Galvano-Faradic Company, rather reluctant, on account of the great expense incurred, to construct the long fine wire coils which he desired, but he had experimented personally enough to note that the suggestions made in his paper, read at the last meeting, were in the right direction.

Dr. Hutchinson thought the committee should report progress, and be continued for another year. It was very desirable to have a definite coil, of a definite resistance; then there would be some means of comparing the results obtained by various observers.

Dr. Massey had devoted his attention chiefly to a consideration of the powers of the primary faradic current to contract muscle, and, in doing so, he noted great differences in this repect in the four Du Bois-Reymond coils in his possession; differences which he attributed to variations in length of the primary wire, in the length and mass of the core, and in the character of the current interruptions.

Dr. Morton said that in view of the fact that induction coils may be made varying in the number of interruptions from twenty per second to 20,000 per second, and that, so far as known, the latter had no effect on the human system, some idea might be obtained of the difficulties encountered by the committee. He suggested that an electrical expert be added to the committee, and mentioned the name of Mr. A. E. Kennelly. By a unanimous vote, this gentleman was accordingly added to the committee.

Dr. A. D. Rockwell, of New York, read a paper on THE USE AND ABUSE OF ELECTRICITY IN MEDICINE. The author referred to a newspaper report of a fatal case of opium poisoning, in which four physicians attempted unsuccessfully to use an antiquated electrical apparatus which they had resurrected from a neighboring drug store; and commented upon the fact that physicians were too apt to be poorly provided with the needful electrical apparatus in a state of good repair. As in such cases artificial respiration may be kept up for hours at a time, it was not at all improbable that this patient's life might have been saved

had the proper appliances been at hand. As an example of the necessity for special training for the practice of electro-therapeutics, as for all other special departments in medicine, he contrasted the treatment of two cases of infantile paralysis. In one there was but little muscular contractility remaining when the case first came for treatment. He subjected the muscles to prolonged and powerful faradization, with the result of entirely extinguishing the little muscular irritability which had been present. The second case was treated patiently and skilfully with the continuous current, with the result of gradually but markedly increasing the power of the muscles. As an instance of the recuperative effect of electricity when intelligently applied, the author then exhibited a patient who, as the result of a railroad accident, had sustained some injury of the radial, median and ulnar nerves. For three months before coming to this physician, the faradic current had been applied at a series of long sittings. When first seen, in May last, there was such profound atrophy and loss of muscular irritability, associated with degenerative reactions, that an unfavorable prognosis was given. At present, however, he is so much improved that he is able to attend to his duties as a mover of baggage. In such a case energy is undoubtedly stored up somewhat as chemical action is stored up in storage batteries. Very few physicians understand the widely different effects to be obtained from the static, galvanic and faradic forms of electricity, and a still smaller number is aware of the great differences existing in the faradic cells themselves. Electricity is a many-sided weapon, and on account of its seemingly paradoxical claims it often excites prejudices. The electrical engineer must be an "expert," but the physician who uses electricity may know little or nothing about it.

Dr. R. J. Nunn, of Savannah, said that the allusion to the case of opium poisoning made him rise in defense of the country practitioners, who are the bone and sinew of the profession. It is absolutely impossible for those working in sparsely settled districts to have at hand all these appliances, and it is not so much their fault as it is their surroundings. Nothing had been said about the intolerance of some patients to electricity. He had sent to the President a patient in whom the current of electricity, so feeble that he could not feel it, was sufficient to set up an albuminuria. This occurred with the galvanic, faradic or static current; it could also be produced by any nervous excitement—such as a long walk, business cares, or by indigestion.

The President said that, on the whole, this so-called "intolerance" of this patient was rather complimentary to electricity, for we are all on the lookout for objective signs of the effect of electricity on the human body. In this case, within three or four hours after the treatment, there could be a marked albuminuria.

Dr. George Apostoli sent a communication on NEW CONTRIBUTIONS OF THE ELECTRICAL TREATMENT, BOTH FARADIC AND GALVANIC, TO THE DIAGNOSIS OF GYNÆCOLOGY, which was read by Dr. Hutchinson. The author said that his observations with the faradic and galvanic current had led him to look upon them as useful aids in diagnosis; and he thought exploratory laparotomies and mutilating operations for ovarian diseases should be prescribed until we had learned all that was possible from such intra-uterine applications of electricity. In 1883 he had shown the marvellous sedative action of the current from a fine wire faradic cell, and further experience had taught him that every hysterical pain of ovarian origin is amenable to this current, and that, therefore, if this current fails to give relief, there is a concomitant affection of the appendages.

While employing the galvanic current in the treatment of fibroids, peri-uterine inflammations, dysmenorrhœa, menorrhagia, etc., he had been struck by the variable intolerance in the same uterus at different times. These variations were found to be due to various physiological and pathological conditions. Thus, in many cases which he had failed to relieve by this current, after the excessive uterine sensibility had been controlled by castration, the electrical treatment could be resumed without special discomfort to the patient, and with positive benefit. In our treatment we must note (1) the operative reaction or tolerance to the current, and (2) the post-operative reaction. The latter is the more important, and may last for several days. In a case which is free from inflammatory adhesions of the appendages, and in which the galvanic current of 50 to 100 milliamperes is employed carefully, and with every antiseptic precaution, it is never followed by a febrile or a very painful reaction; therefore, the more the woman complains during the operation out of proportion to the strength of the current, and the more quickly the pain ceases after the treatment, the more precise is the diagnosis of hysteria. On the contrary, in every case of peri-uterine phlegmasia there is but little tolerance to the current, the post-operative reaction begins quickly, and is prolonged in proportion to the acuteness of the inflammation of the appendages. It may be stated positively that every pelvic suppuration predisposes to intense galvanic post-operative reaction.

Every galvanic application should begin with the positive pole in the uterus, and the current at the commencement should not exceed 50 milliamperes; the application should be interrupted as soon as there is manifest intolerance to the current, and should not be resumed until all post-operative reaction has subsided. If, notwithstanding these precautions, the galvanic treatment is not tolerated, it indicates that there is some inflammatory condition present. Such treatment is not dangerous if the rules laid down are carefully followed, particularly as regards the use of the positive pole at the beginning, and the avoidance of too strong a current. Every uncomplicated ovarian cyst will tolerate high intensities of current applied intra-uterine, and there is no post-operative reaction. Hence, we may conclude that the proper application of the galvanic current to the interior of the uterus informs us as to the condition of the appendages, the degree of inflammation, and whether or not there is pus present. It enables us to avoid mistaking a subperitoneal fibroid tumor for a salpingitis and vice versa. Even if there be a co-existent ovarian cyst without inflammation, the same tolerance will be observed. If with a current of only 20 or 30 milliamperes, the intolerance is excessive, it indicates that the uterus is attacked by a lesion not amenable to conservative gynæcology, and that galvanic treatment must be suspended. Castration will then probably be required.

DISCUSSION.

Dr. Massey thought this the most important paper Apostoli had written and he fully indorsed the views expressed by the author; he thought surgeons would find in this new aid to diagnosis and additional help in enabling them to avoid performing many useless operations. He was convinced, however, that moderate inflammation did not contra-indicate applications to the interior of the uterus, but he regarded the presence of pus in the tube without free exit as a positive contradiction to much interference with the interior of the uterus. He was convinced that both ovarian and salpingitic cases are originally uterine and the question to determine is whether the case is more uterine than ovarian, and this will usually be settled by the treatment. He objected to the rigid electrodes employed by the author of the paper.

Dr. Goelet had utilized the faradic current in the vagina by the bi-polar method to facilitate diagnosis, which it did by inducing a condition of anæsthesia, but had hesitated to use it in the uterus in the manner described by Apostoli because he had found such cases rather intolerant at first of intra-uterine interference because of the co existing endometritis. He thought, however, that treatment of the endometritis, which in many cases is responsible for the continuance of the inflammation in the tubes, would so far relieve the undue sensitiveness as to admit of the subsequent use of electricity for its relief—even cases which were previously supposed not to be amenable to this treatment. He thought it would be decidedly wrong for any one but a gynæcologist to adopt this test for diagnostic purposes. But he did not believe that Apostoli intended to convey the impression that anyone was competent to employ it for this purpose. He could not approve of condemning every case of uterine intolerance to operative interference and did not believe the author of the paper intended it to be so understood.

Dr. Nunn was inclined to regard uterine intolerance to electrical treatment as an idosyncrasy and cited two cases to illustrate this point.

Dr. Rockwell thought that the analgesic effect of the faradic current of tension could be depended upon to remove the apparent intolerance of some of the cases to electrical treatment.

Dr. Dickson, of Toronto, favored the use of mild currents in the beginning where stronger currents were not well tolerated.

Dr. Walker, of Toronto, did not share Dr. Massey's unfavorable opinion of Apostoli's electrode, and expressed himself as much pleased with all of Apostoli's instruments. He spoke warmly in favor of the faradic current of tension for producing sedation in diseased conditions of the appendages.

Dr. Cleaves, of New York, corroborated all the statements of Apostoli concerning the value of the galvanic current, and regarded uterine pain as indicating the necessity of an unusual degree of care in conducting any method of treatment.

The President said that he could not say from personal experience whether or not the fact that all electrical applications which caused undue pain indicated the existence of pus in the adjacent tissues, yet he always looked upon it as a danger signal.

It would appear from the statistics recently quoted by Sir John Lubbock that very few who enter the medical profession entirely fail. Out of the 1,000 medical students whose after-career came under the observation of Sir James Paget, there were apparently only 36 who were unsuccessful owing to circumstances over which they had no control. The actual number of men who did not succeed was 56; but of these, 19 failed through drunkenness, and the same number through ill-health or accident. Twenty of the 1,000 left the profession, but whether they did so because they inherited wealth or married rich wives is not stated. One of the 1,000 was Palmer, the celebrated murderer, who was hanged. —*Ex.*

The death of Dr. Enoch Fithian, of Bridgeton, N. J., on November 15, removes the oldest living graduate, as he was reported to be, of the University of Pennsylvania, from which institution he received his diploma of medicine in 1815. He was born in May, 1792.—*N. Y. Medical Journal.*

Dr. Henry T. Byford has been elected to the chair of gynæcology in the College of Physicians and Surgeons, Chicago, to fill the vacancy made by the death of Dr. A. Reeves Jackson.—*N. Y. Medical Journal.*

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BALTIMORE, DECEMBER 17, 1892.

Editorial.

THE STATE CONVENTION FOR ROAD IMPROVEMENT.

The JOURNAL is requested to give editorial notice of, and to be represented in, this important convention, and gladly accedes, as it has already bespoken among its readers an interest in the matter. It really looks as if the States were in earnest in the determination to secure well-built roads. Everywhere is heard the demand for attention to the subject. Having grown up in Harford County, the editor knows what county roads are like, and he has a profound pity for the spines of the doctors who have to jolt and flounder over them.

The place of convention is central, the hour is convenient, and there ought to be a large attendance on the part of physicians. The notice speaks for itself, as follows:

"The Deer Creek Farmers' Club, of Harford County, which ever since its organization in 1873 has manifested a lively interest in road improvement, being assured of influential co-operation, has issued a call for a State Road Convention, to be held on the 11th, 12th and 13th of January, 1893, at 11 A.M., in the Hall of the Young Men's Christian Association Building, corner of Charles and Saratoga Streets, Baltimore.

"The chief object of the convention is to organize a State Road League, with branches in every county, for the purpose of increasing the interest already awakened in Maryland in behalf of good roads and making such interest effectively felt. The convention, it is expected, will discuss the various methods of making and mending public roads in the several counties, but it may be assumed in advance that no attempt will be made to up-root existing systems, but rather to suggest improvements tending to make each system more effective, so that the best results may be obtained from the money annually levied for road improvement. It is also hoped that some plan may be suggested by the convention

whereby State aid may be given to the counties for the improvement of their public roads.

"Representatives of the various agricultural societies, farmer's clubs, granges, road leagues, railroad and other transportation companies, the Baltimore City Board of Trade, institutions of learning, the Maryland Wheelman's League, together with individuals interested, directly or indirectly, in the improvement of the public roads of our State, have been invited to attend. The club has received satisfactory assurances that the movement will meet with encouragement.

"Any inquiries regarding the meeting may be addressed to Mr. B. Howard Haman, Secretary of the Committee on Arrangements of the Deer Creek Farmer's Club, Room 26, Firemen's Insurance Building, Baltimore.

Among the signatures to the call are the following: John Moores, John B. Wysong, F. W. Baker, Committee of the Deer Creek Farmer's Club; Wm. B. Sands, Secretary Maryland State Farmer's Association; G. W. Lurman, Maryland Vice-President of National Road League; B. Howard Haman, Maryland Director of National Road League; Frank Frick, President Baltimore City Board of Trade; Felix Agnus, Proprietor of the Baltimore *American*; A. Beckhofer, editor of the Baltimore *Herald*; Daniel C. Gilman, President of Johns Hopkins University; John K. Cowen, of the Baltimore and Ohio Railroad; George R. Gaither, Jr., President Alumni Association Maryland University Law School; Albert Mott, for Maryland Division League of American Wheelmen; William T. Dixon, John Gill of R., Robert C. Davidson, Douglass H. Thomas, Conway W. Sams and Thomas K. Worthington.

OUR WEEKLY CHRONICLE.

An interesting medical case has been reported to us on good authority as occurring in the northwestern part of this city during the past fortnight. The patient, a woman, was seized with vomiting and purging of large quantities of a peculiar watery matter. These symptoms were accompanied by cramps in the muscles, wasting of the tissues, and suppression of urine. After the illness had continued about a week in the manner stated, an interesting condition set in, which lasted three days, until death occurred. This condition was one of coldness. The body-surface was said by the attendant to give to the hand a sensation as if one had laid the hand on a marble door-step. The breath was also cold; the voice-tones were hoarse. The intellect remained clear until the end. The purging was less frequent, or ceased during the last days of life.

There were a couple of cases of evanescent gastro-intestinal catarrh in the family during the illness of the patient. The case suggests an interesting disorder, involving the sympathetic system of nerves, which was well known to the past generation of physicians, but is unfamiliar to most of those now in practice. The death certificate suggested, we understand, that the case was of sporadic origin. No treatment seemed to be of any avail in controlling the symptoms or arresting the fatal issue.

There has been a slight recurrence of epidemic influenza in some parts of the city. The symptoms which we have observed are severe catarrh of the respiratory tract, slight aching in certain regions of the body, recurring chilliness, fever with sweating skin, a very moist tongue with yellow coating near the fauces, anorexia, and the affection of several members of the household at or near the same time. Headache has been slight or absent. The treatment used for influenza last year and the year before has been satisfactory.

We hope that the movement for a uniform national quarantine against infectious diseases will not be allowed to languish for want of interest among medical men. The partial quarantine which detains ships in the Chesapeake, but allows them to land in New York, is not only unjust but necessarily inefficient.

We would raise a voice of warning against the supposed preparedness of Baltimore against the possibility of cholera invasion. While the wave of foreign infection may not again advance against us until the spring or summer, occasional cases may at any time occur here and there in the city. We will not undertake here to decide whether the tendency of health boards to conceal such cases or to report them under other names is wise or not. We would, however, warn our subscribers that they ought to keep their eyes open and to form beforehand some definite plan of treatment in case such patients appear in their practice. Our city is not yet clean, in spite of the spasmodic effort at cleanliness made by the authorities some months ago; and it will soon be as dirty as before, unless the authorities are jogged up a bit occasionally. Such grave charges have been made against the Lake Roland water supply that cautious physicians will instruct the families in their charge to have all drinking water boiled, now and for a year or more until the water supply is changed.

The city medical societies would do well to call the attention of the Mayor and City Council again to the need for reform and improvements in the health force. From an infectious case recently related to us we infer that the force is wholly unprepared to meet cholera even if but few cases should occur. It cannot be made efficient until intelligent physicians, awake to the grave responsibilities of their work, fill the offices of sanitary inspectors in infectious diseases.

Without personal ill-will to the Health Officer, and without discourtesy to the inspectors as men, we may say that with reference to the present system of inspectors we feel like the witness who paid with a $20 note a fine of $10 for "contempt of court," but refused to accept the change, as he wished to take the other $10 in contempt.

We hope that our fellow practitioners will stand by us in our desire and effort to secure really efficient sanitation in Baltimore.

As we go to press we regret to learn of the sudden death of Dr. W. Chew Van Bibber, at his residence, 26 W. Franklin Street, of heart disease. He leaves, besides his wife, three daughters, and one son, Dr. Claude Van Bibber, who is now traveling in Europe. The eldest son, Dr. John Van Bibber, died about a year ago, while undergoing a surgical operation.

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Original Articles.

OBSTETRIC SURGERY, WITH REPORT OF A PORRO CASE.*

BY ANNA M. FULLERTON, M. D.

A very much larger proportion of cases of difficult labor arise from pelvic abnormalities than is generally supposed. The lack of attention to the subject of pelvimetry in this country has led to the belief that American women are comparatively exempt from pelvic abnormalities. The graver grades of deformity are, to be sure, seldom met with; thus, the osteomalacial pelvis is not known in this country. The contractions and deformities due to rickets, however, are not at all uncommon, especially among the colored population. Prof. Anna E. Broomall, whose obstetric experience is probably one of the largest in the country, considers the most common abnormalities, taking the population as a whole, to be as follows: Among American-born women, the simple flat pelvis of the first grade of contraction, the average shortening of the antero-posterior diameter of the inlet being but 1 cm. below normal. The next most frequent cause of trouble she attributes to exaggerated inclination of the pelvis. Among the colored race the generally contracted rhachitic pelvis is most common, and the generally contracted flat pelvis the next in frequency. In the management

*Read before the Philadelphia County Medical Society, November 9, 1892.

of labor the accoucheur must be observant of the earliest symptoms of exhaustion on the part of mother or child, and prompt in tendering the required assistance before it is too late.

Among the thousand cases of labor occurring in the service of the Woman's Hospital in the past six years, 19 per cent. required operative interference at full term. There were 8 deaths among the women delivered—less than 1 per cent. All but two of these were due to constitutional disease complicating pregnancy. Two sudden deaths occurred—one from shock following rupture of the uterus in a neglected transverse presentation; the other from air in the heart after a delivery complicated by the pressure of a large fibroid. The fœtal mortality was $4\frac{3}{10}$ per cent. from all causes. In 40 cases in which contracted pelves existed, labor was induced prematurely without the loss of a single mother or child, and thus the complications which might have resulted at full term were averted. Among the other operations performed were 79 forceps applications at the brim and in the upper portion of the pelvic canal, due to difficulty in descent of the head; 75 forceps applications at the floor of the pelvis for uterine inertia and rigidity of the soft tissues; 11 cases of podalic presentation required assistance in the delivery; and 4 craniotomies were performed, all on dead children. One Cæsarean section, one Porro operation, and one symphyseotomy were also done. Inclusive of the induced labors, the percentage of deliveries requiring artificial aid was 23.

Undoubtedly the management, *par excellence*, of moderately contracted pelves is the induction of premature labor; but this necessitates a careful study of the patient's pelvis early in the pregnancy, in order that the time elected for the operation shall be most favorable to mother and child. The advantages of premature delivery to the mother are owing to the diminished head pressure, hence the rare occurence of lesions of the genital canal. The disfavor with which the induction of premature labor has been heretofore regarded has probably been due to the large maternal mortality which attended its earlier performance, and which resulted, doubtless, from the employment of intra-uterine manipulations for its accomplishment, and lack of antisepsis. The large fœtal mortality was due to insufficient knowledge of the needs of the premature infant and lack of care in its nursing. Spiegelberg gives the maternal mortality as 18.8 per cent., and the fœtal as 66 per cent. Among 30 cases in which I induced labor last year there was no maternal or fœtal mortality. It is rarely necessary in this country to perform this operation before the thirty-fourth week for pelvic contraction.

The aid of the couveuse—or hatching-cradle for infants—was very appreciable in the management of the premature infants born in our Maternity; and when, as in France, the use of the apparatus becomes more general, the induction of premature labor will, I believe, stand in higher favor in our own country.

The performance of version and extraction in contracted pelves exposes both mother and child to perils of no insignificant character. Borinski, collecting the statistics of version from the Breslau clinic, reports 58 cases of version in ordi-

nary flattened pelves, with the result that just one-half the children were born dead. Three of the mothers died from results connected with the operation. In speaking of the high forceps operation, Professor William T. Lusk refers to the collected cases reported by Dr. Harold Williams. Among 119 cases, of the mothers nearly 40 per cent., and of the children over 60 per cent., perished. "So long as the head does not engage at the brim," says Professor Lusk, "there is no rivalry between version and forceps. The latter should be placed under the ban as hardly less dangerous than the Cæsarean section." Version, however, is not applicable to the generally contracted pelvis; hence, in the revival of symphyseotomy we hope to find a method of procedure which will solve the difficult problem of non-fixation of the head in just such cases, and entirely do away with the barbarous practice of craniotomy on a living child. The operation is still in its probation in this country, but the brilliant results attained in Europe, as reported by Dr. Robert P. Harris, lead us to hope that we have in symphyseotomy an operation by which far less destruction of the maternal tissues shall result than can be claimed for either forceps or version, and by which, also, the injurious effects of pressure upon the fœtal head may be averted.

From the histories of reported cases, the chief objection to this operation, which lies in the possibility of non-union of the divided symphysis, would seem to be removed. In the only case of which I have any practical knowledge—that performed by Professor Anna E. Broomall, on October 10th, in our Maternity—the union is apparently perfect. Hubert, in a recent article in the *Archives de Tocologie*, warns us against the separation of the pelvic symphysis in mothers who are too old.

In cases of absolute pelvic contraction, where the conjugata vera falls below 6½ cm., and in the deformed pelves in which there is extreme narrowing, delivery by abdominal section is indicated. The two forms of operation usually resorted to are the Sänger modification of the classical Cæsarean section and the Porro-Müller amputation of the uterus. Two operations of this class have been performed in our Maternity wards during the past six years. The first was a Cæsarean section performed by Dr. Anna E. Broomall, on a patient with a generally contracted rhachitic pelvis. Both mother and child did well after the section.

The second case of abdominal delivery was one performed by myself a little more than six weeks ago. The patient was a primipara, aged twenty-four years; four feet eleven inches in height; rhachitic, with marked kypho-scoliosis. Due to an old unreduced dislocation of the hip-joint, there was ankylosis with marked lateral obliquity of the pelvis and a beak-shaped pubic symphysis. The conjugata vera was estimated at 7 cm. The patient was admitted to the Maternity wards of the hospital suffering with an acute bronchitis superimposed upon an attack of rheumatism. She was then in the latter part of the eighth month of pregnancy. When she had recovered from her illness, a consultation was held; it was decided to deliver by abdominal section when the patient was nearer full term.

On September 26th I performed the operation, assisted by Dr. Broomall, several other physicians being present by invitation. The nature of the operation had been explained to the patient's friends as well as to herself, and it was left to them to decide as to whether the uterus should be removed or not after the delivery. My own feeling was strongly in favor of the uterine amputation, as it seemed to me totally unnecessary to preserve the childbearing function in a woman incapable probably of bearing healthy children, and bearing them, at any rate, at such risk. The parties concerned agreed with me in the matter, and the Porro operation was done. The uterus was lifted out of the abdomen before the uterine incision was made, and the rubber cord applied, as usual, for the control of hæmorrhage. Very little blood was lost. No fluid entered the peritoneal cavity. The child gasped as soon as delivered and was soon crying quite vigorously. The uterus contracted firmly as soon as emptied. Before the delivery of the child, hæmorrhage was controlled by Dr. Broomall grasping her hand around the neck of the uterus; after the delivery the rubber cord which had been placed was tightened. The placenta was delivered and the uterus cut away, after the application of a wire ligature. The stump was secured in the lower angle of the abdominal wound. I strongly desired to follow the method suggested by Dr. Baer, of ligating the uterine arteries and dropping the stump, but not having the same familiarity with this method as with the original one of clamping it, I refrained from running any risk. The mother made an excellent recovery and is perfectly well to-day. The child, a girl, weighing six and a half pounds at its birth, now weighs nearly nine pounds, and is in good condition. The operation was done about a week before full term.

THE TREATMENT OF HEMORRHOIDS.*

BY JOHN B. DEAVER, M. D.

In opening the discussion upon the treatment of hemorrhoids I will confine the few remarks I have to make to what I consider the most essential points, and first a word as to the formation of this form of tumor and its varieties.

To understand the origin of piles we must be familiar with the arrangement of the veins of the rectum. The hemorrhoidal veins number three—the superior, middle and inferior. The superior empty into the portal system, while the middle and inferior empty into the general venous system. In the upper part of the rectum they are arranged longitudinally, while below they are arranged circularly in the shape of a plexus, the hemorrhoidal situated between the mucous and muscular coats. As the hemorrhoidal veins are destitute of valves, also owing to the office of the rectum and to the erect position, these veins are very liable to become dilated and varicose.

To speak of a dilated and varicose condition of the veins in themselves consti-

*Read before the Philadelphia County Medical Society November 23, 1892.

tuting a hemorrhoid is a mistake. The first step in the formation of a hemorrhoid is a dilated and varicose condition of the veins, I admit, but in addition to this condition of the veins there must be associated with it inflammatory exudate.

Hemorrhoids are divided into three varieties—external, internal, and intero-external. Hemorrhoids which protrude at stool and are capable of being replaced and retained within the sphincter are of the internal variety, while hemorrhoidal tumors situated outside of the sphincter which cannot be forced inside are of the external variety. The intero-external variety is a combination of the external and the internal. This variety occupies the verge of the anus, and is covered by both mucous membrane and skin.

The internal hemorrhoid is a varicose and dilated condition of the superior hemorrhoidal vein, therefore an affection of the portal system. The external hemorrhoid is a like condition of the middle and inferior hemorrhoidal veins, therefore an affection of the general venous system.

In the intero-external variety both sets of veins are involved.

External hemorrhoids are met with in any one of three different forms. The first is simply a venous tumor, the result of a phlebitis and consequent thrombosis of a varicose vein; the second, a tumor composed of dilated and varicose veins with proliferation of the surrounding connective tissue; the third, a tumor made up almost entirely of proliferated connective tissue.

Internal hemorrhoids are met with as one of two forms: the capillary and the venous. The capillary hemorrhoid is composed of the terminal branches of the arteries and veins and intervening capillaries. It is this form of hemorrhoid which bleeds upon the slightest irritation; its surface, too, is granular, and presents somewhat the appearance of a strawberry. The venous hemorrhoid is made up of anastomosing veins and connective tissue; this I regard as but an advanced stage of the capillary hemorrhoid.

The treatment of hemorrhoids is palliative and radical. Concerning the palliative treatment I will have but little to say other than that I regard having the bowels move daily, and observing the strictest cleanliness, the most important indications to be fulfilled. Doubtless, in some instances one or other of the various astringent ointments, so commonly used, may be of some advantage, yet I have little faith in their accomplishing a cure.

Before recommending radical treatment, the case is first to be thoroughly examined to determine whether such a procedure is justifiable.

Hemorrhoids may be symptomatic of visceral disease, of structural changes in the wall of the rectum above the pile-bearing area, such as carcinoma, stricture, etc. Under these circumstances the proper treatment would be the correction, if possible, of the condition giving rise to the hemorrhoids. Again, they are often secondary to disease of the uterus, the bladder—as when a calculus is present—an enlarged prostate or a stricture of the urethra, etc.

In advising radical treatment a careful examination should be made first to

determine whether any of the previously mentioned conditions are present or not. The urine is to be carefully examined, when, if albumen is present and dependent upon heart or kidney affection of a serious character, operation is to be strongly advised against.

The Radical Treatment of External Hemorrhoids.—In the first form, that of the venous tumor, the result of phlebitis, thrombosis, etc., it will suffice to incise the tumor freely, and turn out the clot, after which the wound is to be packed gently, and thus favor healing from the bottom. In the second variety, that of dilated and varicose veins with proliferation of the neighboring connective tissue, it will often suffice to stretch the sphincter muscles, when, if this fails, I strongly recommend removal of the tumor with the clamp and cautery; in the third variety of external pile I also use the clamp and cautery. In either of the two latter varieties, when the tumor or tumors assume considerable size, it may not be possible to engage them individually in the clamp; under these circumstances they should be bisected, as it were, and each half clamped, the redundant portion cut away and the pedicle cauterized. It is in this variety of pile, when involving the entire circumference of the anus, where the Whitehead operation is applicable, but so far as my observation goes it does not offer any advantages over the clamp and cautery. When the external pile presents itself in the shape of a tab of skin it will suffice to remove it with a pair of scissors; in the event of bleeding following, it can usually be checked by the application of a wad of styptic cotton, over which is placed a compress and bandage, or the bleeding point may be touched with the point of the cautery. In the second and third forms of external pile, if inflamed, tense and painful, I think it much more satisfactory to etherize the patient and remove them at once, and not attempt to reduce the inflammation by the application of lead-water, laudanum, poultices, etc. I have found this a much quicker way to dispose of them and at the same time less painful to the patient.

Operations for Internal Hemorrhoids.—In few departments of surgery have there been more operations devised for the cure of any one condition than that of internal hemorrhoids.

The following is a list of the most important which have been advocated:

Excision; removal with wire écraseur; injection with carbolic acid or an astringent; the application of acids; removal by the galvanic cautery wire; dilatation of the sphincter muscles; clamp and cautery; crushing-ligature and Whitehead's operation.

Of these, I have had experience with the clamp and cautery, ligature, injection of carbolic acid, Whitehead's, and dilatation of the sphincter muscles. I now, however, rarely do any other than the clamp and cautery.

The advantage which the clamp and cautery possess over all other procedures is its universal application. The instruments required to perform this operation are a Smith's clamp and a pair of pile forceps, a pair of scissors, and a Paquelin's cautery. A tenaculum or vulsellum may be used in place of pile forceps.

The first step in the operation is the dilatation of the sphincter, which is

followed by protrusion of the piles. The piles are now grasped with the forceps and the clamp adjusted. With the scissors the pile is trimmed down, leaving a pedicle one-quarter of an inch in length above the clamp. With the cautery iron at a dull-red heat the pedicle is reduced one half, presenting a charred and dry surface. The clamp is now removed and the edges of the stump allowed to fold in. By leaving a pedicle as described, bleeding cannot follow the removal of the clamp. In cases where the pile-surface is muco-cutaneous, before the clamp is adjusted the skin should be divided with a pair of scissors, thus eliminating pain and subsequent contraction. The operation is completed by the introduction of an opium suppository, dusting the surface with iodoform, and the application of an antiseptic dressing. The after-treatment consists of rest in bed, light diet, and of the administration of one-quarter of a grain opium pill night and morning for from three to four days, when the bowels are moved by a laxative and an enema given when the desire to defecate is felt. After this the patient is allowed the freedom of the room.

The advantages of this operation are freedom from hæmorrhage, the rapidity with which it is performed, the absence of pain in the majority of cases, the absence of retention of urine, and the patient's being able to resume his or her occupation ordinarily in from one week to ten days. Pain, irritability of the bladder, and prolonged convalescence occur in neurotic subjects. Further, I believe tetanus is less likely to follow this than any of the other operative procedures.

The objections to the ligature are the pain which follows the tying of the pile, retention of urine, the amount of blood lost in debilitated subjects, and the prolonged convalescence consequent upon the process of separation of the ligatures.

The objections urged against the injection of hemorrhoids are the liability of sloughing and fistula, the formation of abscess, the possibility of a diffused inflammation with pyæmia, an extension of the inflammation to the peritoneum, and embolism. While injecting a pile the base should be constricted until coagulation takes place, to prevent an embolus from being carried into the circulation.

The objection to the Whitehead's operation are the time required for its performance, the amount of blood lost, and the danger of the stitches cutting out, leaving a circular granulating surface which may result in atresia of the rectum. Again, it is only applicable in a comparatively small number of cases.

Dilatation of the sphincter muscles, like the Whitehead operation, is only applicable in a few cases, especially those of recent origin, and in the case of prolapsed hemorrhoids which are prevented from repositing themselves on account of being grasped by the sphincters. In the former instance it may suffice to bring about a cure if proliferation has not taken place to any extent, which is always questionable. In the latter case it can only offer a palliative means. When internal hemorrhoids become strangulated and gangrenous, they should at once be removed, preferably with the clamp and cautery.

Society Reports.

TRANSACTIONS OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

SECOND ANNUAL MEETING, HELD IN NEW YORK, OCTOBER 4, 5 AND 6, 1892.

FIRST DAY, OCTOBER 4, AFTERNOON SESSION.

Dr. G. Betton Massey, of Philadelphia, read a paper on A NEW TREATMENT OF PROSTATIC HYPERTROPHY.

The author said that in order to understand the action of the current on the prostatic gland, one must remember that the bulk of this organ is made up of muscular tissue, and the chief feature in the treatment consisted in the development of the constringent power of the electric current. While mild currents are useful in superficial prostatitis, they will not answer in prostatic hypertrophy. Here, "swelling currents" should be employed, the current being increased from 20 to 70 milliamperes, but only allowed to remain at the maximum strength for a few seconds. If the manipulations are conducted with scrupulous cleanliness and great gentleness, and the sittings repeated not oftener than every five days, the treatment will be followed only by a feeling of relief. The primary current is also used at each sitting, and the author considered it a valuable part of the treatment. He had found this same method also of service in a condition often associated with hypertrophy of the prostate, *i. e.*, a diminished contractility of the bladder. The speaker exhibited a home-made instrument which he had employed for this treatment. It consisted of a silver catheter, with a large prostatic curve, which is covered with fused rubber, except just at the eye. The instrument being hollow, enabled one more easily to locate the position of its beak.

DISCUSSION.

Dr. Rockwell had been unable to obtain satisfactory results from the electrical treatment of these cases, either by the method described, which is the ordinary application, or by a number of others which he had tried. He had had an opportunity of treating, recently, a case of marked prostatic hypertrophy, on whom suprapubic cystotomy had been previously performed, so that there was an unusually good opportunity for observation. With an insulated needle introduced through the abominal opening, the prostate was pierced to the depth of one-quarter of an inch, and a current of from 15 to 30 milliamperes employed on several occasions, but when the current was finally increased to 50 milliamperes, the treatment was interrupted by the development of an orchitis. With the subsidence of this inflammation there was a notable decrease in the prostate gland, allowing the patient to pass his urine quite freely. Afterwards the needle connected with the negative pole was introduced into the prostate through the rectum.

Dr. Massey, in closing, said that his experience in this treatment was limited to two cases, both successful. In the first one, that of a man 73 years old, who had been unable to urinate spontaneously, the patient had recovered this power, and had not lost it a year or more later. In the second case rectal touch showed a marked diminution in the size of the gland after the treatment.

Dr. Frederick Peterson, of New York, opened a discussion on (*a*) ELECTRIC CATAPHORESIS AND ITS PRACTICAL APPLICATION AS A THERAPEUTIC MEASURE.

DISCUSSION.

(*a*) Opening of the discussion by Dr. Frederick Peterson, of New York.

He said that no definite scientific experiments bearing upon the medical aspect of this subject had been made previous to those which he carried out in the winter of 1888-89, at which time he was especially interested in the treatment of severe neuralgias with galvanism. His first experiments were made upon himself, then upon medical friends and patients, and since his first paper containing the details of these experiments was published, other observers had abundantly confirmed his results. There is a streamy movement of the electric current from the positive to the negative pole sufficiently powerful to carry substances in solution through the skin. This is a purely physical action, and in no sense electrolytic. The solution of the drug must be placed on the anode only, and the greater the resistance of the fluids, the more powerful will be the cataphoric effect of the current. There are various ways of producing the cataphoresis, one of the best being with the cataphoric electrode. This consists of a metal disk, on which is a disk of blotting paper, moistened with the solution; thus, a thin film of a known quantity of fluid may be employed and the diffusion greatly accelerated.

(*b*) THE PHYSICS OF CATAPHORESIS, by A. E. Kennelly, Esq., chief electrician of the Edison Laboratory, and Prof. E. J. Houston, of Philadelphia. In the absence of Mr. Kennelly, his paper was read by Dr. Peterson.

The author dealt largely with certain physical phenomena, a knowledge of which is necessary to a proper understanding of cataphoresis. When two liquids, similar or diverse, are brought into communication by a narrow channel lined by insulating material, such as a glass capillary tube, or a porous diaphragm, a current is produced, and is usually accompanied by a flow of fluid from that which is positive to that which is negative. If the fluids in the two vessels are not on the same level, there will be the usual tendency to re-establish the equilibrium, but on passing through the electric current, the effect is superposed upon whatever flow may already exist. Hence, in a study of cataphoresis these associated conditions should be eliminated. Given a definite porous septum, and a liquid in its pores, the total quantity of liquid transferred depends upon the amount of electricity transferred, and the result is apparently not affected by the extent of surface of the septum, or by its thickness. The nature of the diaphragm, and of the solution employed, have much to do in determining the quantity of fluid transferred. It must be remembered, also, that the contact of two dissimilar substances gives rise to a current between them.

The author then stated various laws governing the motion of solid bodies and of fluids. The rate of transfusion will not be altered by any changes in the length of the tube. The only function of the electric current in cataphoresis is to establish a gradient of potential. There is a general tendency for aqueous solutions to move from the anode to the cathode. Water, when subjected to friction with glass, also develops a positive potential. While not strictly true, it may be stated, as a general rule, that the transfer of a liquid is inversely proportionate to its solid contents. In conclusion, the author said that while the theory of cataphoresis seems to satisfactorily explain the facts, the measurements which have been made are all too few.

The discussion was then taken up by Prof. Edwin J. Houston.

He said that by the term cataphoresis is meant the introduction of drugs or medicaments into the body by means of the electric current, and this is dependent upon electric osmose, or electrical endosmose, as it is more commonly called. Cataphoresis is simply a variety of osmose, and by the term osmose is meant the unequal diffusion or admixture of liquids of different densities through the pores

of a diaphragm, separating the liquids from each other. Each liquid tends to mix with the other, but the flow is unequal in strength, and hence, there is a higher level produced in that liquid towards which the greater flow is directed. The endosmotic current is that current which is directed towards the higher level; the other is called the exosmotic current. The phenomena of osmosis are intimately associated with those of diffusion. Ordinary osmose appears to be unquestionably accompanied by an electric current which is passed through two liquids across a porous wall which separates them. The movement of the liquid takes place in the direction of the current, and, therefore, the electro endosmotic current is the one which passes through the septum in the same direction as the electric current. By a similar process, called cataphoresis, fluids may be made to pass through the skin or other membrane of the human body, by the action of the electric current. As the causes of osmosis are not well understood, and our knowledge of the causes of electro-osmosis is still more limited, a study of the phenomena of cataphoresis from the standpoint of the physicist must fail, unless supplemented by the studies of the physiologist and the practising physician. The following are the author's conclusions:

1. That the effects of the electro-endosmose, or cataphoresis, are more general than heretofore suspected. Thus, whenever an electric current is sent through the human body, whether for ordinary therapeutics, or for some definite cataphoric effect, there must be a true cataphoresis, for there must be produced a flow of the fluids in the body in the direction of the current. It follows, therefore, that the effect of the passage of a current must be to engorge certain parts, and to deplete others, and it is possible that the therapeutic value of the current may arise mainly from such action. Its beneficial effect may, however, also be dependent upon the establishment of a more uniform condition of pressure in the various tissues, or on the transference of morbid products. This, probably, explains why in so many cases one electrode only is active.

2. Since cataphoric action presumably accompanies the passage of an electric current through the human body, the resistance of the various parts of the body cannot remain uniform, even while their resistance is being measured—a condition very different from that of ordinary conductors. Any change in resistance, due to cataphoric action, should be symmetrical.

3. There are two varieties of cataphoresis: (1) Normal cataphoresis, by means of which a disturbance is effected in the distribution of the constituents of the human body by the passage of any electrical current; and (2) abnormal cataphoresis, by which fluids are introduced into the human body from without by the passage of an electric current.

(*c*) Its uses in general medicine, by Dr. W. H. Morton, of New York.

Dr. Morton said that he had been in the habit of excluding chemical osmosis from the phenomena of cataphoresis, for the reason that osmosis may exist without cataphoresis, and one may even antagonize the other. There has been much confusion concerning the direction of the flow connected with cataphoresis, for solid particles, when suspended in a fluid, pass from the positive to the negative, or from the negative to the positive pole. Again, methyl blue goes from positive to negative pole, and eosin from negative to positive. Such facts show that to a certain extent the term "anodal diffusion" is a misnomer. Regarding this subject, however, three broad statements may be made, which are well sustained by various observations. They are: (1) In a fluid or semi-fluid conductor, like the human tissues, there is a movement of the fluids from the positive to the

negative pole; (2) Extraneous fluids maintained in contact with the skin or mucous membrane are transported from the positive towards the negative pole, and in this manner medicinal substances may be made to penetrate the skin and enter the tissues and the circulation; (3) It has been demonstrated with tolerable certainty that medicinal substances in the tissues in a state of solution may be removed by the action of the electric current. This knowledge justifies two distinct divisions of the subject: (1) Cataphoresis, or simply fluid transportation, (2) cataphoric medication and de-medication. It is difficult at present to say which will be more useful in therapeutics.

The author then described a number of interesting experiments on animals which had been made by G. M. Stewart, of the physiological laboratory of Owens College, Manchester, England, and by Newman and Harries, of London. The gynæcologists have used currents of such density that the so-called hæmostatic or drying effect of the positive pole may well be due to the removal of fluids, and the liquefying of the negative pole to cataphoresis. The dense currents employed in the treatment of fibroid tumors produce contraction of the uterus and diminution of the vascular supply of the tumor, with a loss of its salts. The removal of the salts is the most important element in this treatment.

Regarding cataphoric medication, the author said he had often applied to the body an electrode moistened with a solution of iodide of potassium, and subsequently detected the presence of iodide by an examination of the urine. He had also been able by the same action of the electric current to drive particles of graphite so deeply into the hair follicles that they would remain there for weeks. The objection to this method of medication is that the dose cannot be determined with accuracy. Dr. Peterson's method, which is the best yet devised, measured accurately the dose applied, but not the actual amount introduced into the system by the flow of the current. In this connection it must not be forgotten that if we admit electrolysis as an element of cataphoresis, it is quite possible that medicines, when introduced in this way in their nascent state, may have special efficacy.

There are two systems of introduction: (1) by the ordinary electrodes, and (2) by electric baths. The writer published in the *New York Medical Journal* for April 25th, 1891, an account of a method of introducing lithium salts into rheumatic joints by a method which is termed "anæmic cataphoresis"—a method of treatment which since then had continued to yield most satisfactory results. Owing to the present confused state of electro-physics, it has been his custom to apply the dissolved medicine to both electrodes. Also, with the aid of that special form of the static current, which the author had previously described under the name of "the static current," he had been able to produce a cataphoric anæsthesis and to introduce into the body a great variety of medicinal substances. He also described an interesting experiment which he had made with the static machine to illustrate the transporting action of the current. If glycerine be placed on the positive pole, and the two poles brought about half an inch apart, on setting the machine in operation the glycerine will be seen to travel across from one pole to the other. This transference of the glycerine will not occur if the glycerine be placed on the negative pole.

The efficacy of electric baths has long been a much mooted point. Owing to their very general adoption by quacks, there has arisen a very decided prejudice against them. Nevertheless, the experiments of Mr. Edison, Mr. Kennelly, and other scientific observers of repute, prove beyond a doubt that medicines can be introduced in this way through the unbroken tissues of the body. Austrian and

German observers have introduced corrosive sublimate in this way, and have been able to find notable quantities of mercury in the urine for several days afterward. De-medication is not ordinarily called for, since it is probable that the natural methods of elimination are usually all-sufficient, but it has proved useful in the treatment of ulcers from which electro-platers sometimes suffer.

In conclusion, the author said that while admitting the foregoing statements to be facts, we are not yet in a position to a judicial expression as to the value of these methods of treatment.

(*d*) ITS USE IN GENERAL SURGERY, by W. H. Walling, of Philadelphia. (Read by title.)

(*e*) ITS USE IN GYNÆCOLOGY, by Dr. Augustin H. Goelet, of New York.

Dr. Goelet said that he considered cataphoric medication had had only a very limited sphere of usefulness in gynæcology. He had experimented at one time with the positive pole in the vagina, moistened with solutions of morphia and cocaine, and had obtained fairly good results, but he had been led to abandon this line of investigation on account of the superior effects obtained with the faradic current in the way of relieving pain. A novel method of employing cataphoresis consists in molding plaster-of-Paris around a platinum wire, and saturating the plaster with the drug which it is desired to introduce. At present, he only employed cataphoresis for the purpose of producing anæsthesia of the vaginal surface previous to making punctures. This is readily done by moistening the electrode with a four or eight per cent. solution of cocaine, and employing a current of 10 or 15 milliamperes. It not only renders the punctures painless, but materially lessens the subsequent aching.

(*f*) ITS USES IN NERVOUS DISEASES, by Dr. Frederick Peterson, of New York.

Dr. Peterson said that after vainly endeavoring in various ways to control the pain of severe supra-orbital neuralgias, he had found that the application of a galvanic current with the anode moistened with a 10 or 20 per cent. solution to cocaine gave absolute relief for a period of from four to ten hours, and withouf producing any constitutional effects. As this cataphoric anæsthesia does not seem to mitigate neuralgias having their origin far back of the seat of pain, it is probable, as Dr. M. A. Starr has suggested, that this method also possesses some diagnostic value. He had experimented with a great many other substances, but had found cocaine most suitable for producing anæsthesia; chloroform produced a dermatitis, and helleborin, although producing deep anæsthesia, also causes much smarting.

GENERAL DISCUSSION.

Dr. Massey said that he had found cataphoric anæsthesia of service, chiefly in very superficial conditions, and, therefore, it had but a very limited field of usefulness in gynæcology. The objection to this method of treating enlarged glands in the neck with iodide of potassium is, that a strong current cannot be used, on account of the great irritation of the skin which it produced. Under this treatment, he had found that tumors would be considerably swollen for some days after the application. He had, therefore, employed his favorite soap electrode with a current of 60 milliamperes, and after persevering in this treatment about one month, he found the glands had diminished. He had also found the method of electric elimination very useful on one occasion, when during the removal of hairs from the face by electricity, he accidentally connected the iron needle, which he was using, with the positive pole, thus producing an iron stain. By reversing the current, the stain was quickly removed by the metal being re-deposited on the needle.

Dr. W. F. Hutchinson said that with the exception of a very few observers,

notably Drs. Peterson and Morton, most of the members had accomplished very little with electro-cataphoresis, and he thought this was due chiefly to our confused knowledge of the physical laws governing its action.

Dr. F. Von Raitz, of New York, said that many good observers differed widely in their statements on this subject; some claiming only anodal diffusion, others only cathodal diffusion, while still others believed that it occurs at both poles. In the paper which he read before the Association, a year ago, he had called attention to the fact that certain substances have an affinity for one pole, and certain others for the other pole, and hence the varying degrees of diffusion from the poles.

Dr. R. J. Nunn said that he had made some experiments regarding mercurial de-medication, and had failed to confirm Vernier's experiments and claims. In his experiments in cataphoresis, he, too, had employed the solution on both poles, because he thought it might produce a better diffusion in the tissues, and he believed he had seen benefit from it. He did not favor the use of an iron needle for the removal of hairs; a gold one was much more delicate, and would last for many years.

Dr. E. L. H. McGinnis, of New York, said that his experience with cataphoresis was limited to a few cases, and in these, he had obtained no marked results.

Professor Houston, in closing the discussion, said that he could not agree with the President that osmosis can be neglected in the study of physics of electro-osmosis. As it is a mutual but unequal mixing of the fluids, there must be a transportation of material from the negative to the positive pole, as well as from the positive towards the negative, and, therefore, he saw no good reason for placing the same material on both electrodes. The fact that the current, depending upon its direction, aids or retards the cataphoric current, shows how intimately electric phenomena are associated with ordinary osmosis.

THE CHOLERA IN HAMBURG.

At a recent meeting of the Bradford Medico-Chirurgical Society (*Lancet*), Dr. T. Whiteside Hime read a paper on his personal experiences of the cholera in Hamburg. The population of the affected area he computed as about 620,000, in which there were 18,000 attacks in six weeks and at the worst 1136 in one day. All arrangements, as, for instance, in regard to the disposal of the dead, were bound to break down under such pressure. On analysis the composition of the drinking water of Hamburg is found to be similar to, but about six times as concentrated as, the sewage of Bradford or Leeds. The treatment by transfusion of a litre and a half of normal saline solution gave most astonishing results; and drugs, especially morphia, being more harmful than useful, calomel was given in minute doses, and hot tea and coffee as stimulants. Personally, if in cholera, Dr. Hime would like perfect rest, transfusion of a pint of normal saline extended over three-quarters of an hour, and then hot alcoholic drinks. There is no characteristic lesion found after death; the kidneys are dusky or livid, and the lungs generally collapsed and full of infarcts. With regard to etiology, cholera will spare one place and attack another, which appears similar in regard to filth and unwholesomeness. It is found to avoid places on impervious granite or clay and to prevail on porous soils. The river has been lower in Hamburg this season than ever recorded. A prevailing epidemic of cholerine is found to be true cholera by the presence of the comma bacillus; at first the cases are mild, later the disease increases in intensity. The water theory does not hold in the case of Hamburg, where the disease behaved as in a town with good water-supply, spreading from the poor and then to the rich.

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BALTIMORE, DECEMBER 24, 1892.

Editorial.

CODEINE FOR THE MORPHINE HABIT.

Great hope has been cherished by the profession that codeine will be found to be a substitute for morphine in many diseases, soothing pain without causing disturbance of the digestive organs or leading to a drug habit. It is pleasant to note that the use of codeine is becoming more general, as its manufacture becomes more reliable.

In regard to its use in the cure of the morphine habit the editor has had little information, although he knew that a secret cure employed in a West Baltimore institution depended somewhat for its success on the administration of codeine.

It is, therefore, with pleasure that we acquaint our readers with some facts given in a pamphlet just received from the well-known authority on this subject, Dr. J. B. Mattison, of Brooklyn. The subjoined statements are wholly from his pamphlet:

Codeine is a remedy of value in the treatment of opium inebriety, serving a good purpose in every phase. In the writer's hands during the last two years it has largely improved the therapeutics of this disease, so that at no time in his experience of more than two decades has it been so satisfactory as now. This good has been secured with less complex treatment, with more freedom from unsatisfactory—sometimes—symptoms and sequelæ, and with a general result gratifying to patient and physician alike. Dr. Schmidt testifies thus concerning it: "It moderates the symptoms incident to withdrawal, even to the point of tolerance; as it contains no morphine it cannot prolong the duration of treatment; it causes the morphine craving to vanish permanently; and the disagreeable collateral effects which develop with the increase in the dose, prevent the misusage of this narcotic as a remedy. With the aid of codeine and meco-narceine I have succeeded in effecting a real cure of the morphine disease. After reducing

the morphine to a very small dose by progressive withdrawal, I resort to the substitution of codeine. I employ for this purpose only exactly as much as seems necessary to relieve the symptoms of withdrawal. As the latter grow weaker, and gradually vanish, the codeine is reduced proportionally, until the last traces of the symptoms of abstinence, as well as the excitable nervous debility, disappear."

We have used Schmidt's method, somewhat changed, and with success. The main change has been in not taking so long a time—months—for the morphine disusing, but to lessen it rapidly—within a fortnight, if possible—to one-half grain, or less, for a dose. Then we substitute codeine, using treble the former amount of morphine, and giving four doses daily, morning, noon, night, and bed-time. These doses are continued for a week, or till the system settles down to the new order of things, and then the noon dose is omitted. In three or four days the night dose; then the morning one, and, last of all, the bed-hour portion. All the time a tonic is employed, our favorite being phosphorus, strychnine, arsenic and quinine combined, with which the codeine can be given, and thus the better permit its quitting unknown to the patient. If minor reflex symptoms present they are controlled as required. Narceine we have not used in these cases. It is mainly hypnotic, but for this need we have given sulfonal, paraldehyde, or chloralamid, according to case and condition.

The cases in which we have used codeine after this fashion have been those of moderate (in time and amount) addiction, and it has served us well. It is also specially adapted to patients greatly enfeebled from large or lengthy taking of opium, in whom a prolonged tonic course, both before and after the disuse of morphine, is essential, and with whom the injurious effect of opium-taking should be ended as soon as possible; the codeine being continued for several weeks if necessary.

To speak tersely, the Mattison method is a withdrawal of the habitual narcotic gradually during ten days, so as to avoid both the cruel and inexcusable pain which attends abrupt disuse and the tiresome delay of prolonged decrease. Meantime a sedative effect on the spinal system is secured by bromide of sodium, beginning with 30 grain doses, twice daily, and increasing the dose 10 grains each day—that is to say, 30, 40, 50 grains—till a maximum dose of 100 grains is reached on the eighth day. On the ninth and tenth days a 5 scruple evening dose only is given. Thereafter, whatever reflex symptoms may present are met mainly by codeine.

As a rule, it is not needed before the eleventh day. Exceptionally, a dose or two may be required in the latter part of the ninth or tenth. When its active use is begun, it is given every two to four hours, in doses of 1 to 3 grains, by mouth or subcutaneously, and this continued, gradually decreasing the dose, or increasing the interval, till no longer required. Meantime other measures are used, as the case seems to demand, but the main "spoke" in the "wheel" of treatment is codeine.

Pure codeine is not suited to subdermic use. It dissolves in acid, and may be given by mouth.

The salts fit for hypodermic use are the phosphate, soluble in 4 parts cold water; the muriate, in 20 parts; and the sulphate in 40 parts. The muriate is soluble in equal parts boiling water.

TO SUBSCRIBERS.

We are requested by the proprietors of this JOURNAL to remind certain subscribers who are in arrears that the very nicest Christmas gift they could send him, if they desire to attest their appreciation of his efforts to furnish them with improving literature of a medical sort, would be a check or other remittance for unpaid subscriptions. It is a good thing to wind up the old year without debts and start the new year on the "prompt payment" principle.

Obituary.

DR. W. CHEW VAN BIBBER.

It was with deep regret as a physician, and with a sense of personal loss, that we chronicled in our last issue the sudden death, in the 69th year of his age, of Dr. W. Chew Van Bibber, one of the best known of Baltimore's physicians. After a busy morning of apparently full health spent in visiting his large circle of patients, he returned to his office a little after midday, complaining of feeling unwell. Twenty minutes later he was found unconscious in his office, death following before medical aid could reach him.

While appreciating the severity of the shock with which this sudden death must fall upon the bereaved family, and especially upon the only surviving son, Dr. Claude Van Bibber, who is now traveling in Europe, we are yet impressed with the fitness of such an ending of a life full of kind deeds and tireless ministry to the distress of suffering humanity.

While in his later years Dr. Van Bibber was chiefly occupied with the multitudinous cares of a very large practice; in his earlier years, he was likewise (as we learn from that priceless repository of medical biography, Dr. Quinan's *Medical Annals of Baltimore*) very active in those departments of professional life to which the energetic physician naturally turns in hours of leisure.

His literary work was quite extensive. He was co-editor for three years, 1856-9, of the *Virginia Medical Monthly*, and for two years, 1859-61, of the *Maryland and Virginia Medical Journal*. Among his contributions to other journals we find clinical papers on Pseudo-Membranous Laryngitis, on Prolapse of the Funis, on Tetanus, on Vaccination, etc.; an analysis of 4,300 cases of labor from the practice of Dr. P. Chatard (his father-in-law); and numerous dissertations upon hygienic themes, among which is an address entitled "The Influence of Light upon Health" delivered before the Peabody Institute in December, 1869.

He took great interest also in the establishment and conduct of city medical associations. He was one of the founders of the Clinical Society, and was active in several others, holding the offices of Secretary of the Old Pathological Society;

President of the New Pathological Society; Treasurer of the Baltimore Academy of Medicine; and Chairman of the sections on Materia Medica, and on Obstetrics in the Medical and Chirurgical Faculty.

Upon his medical skill we need not comment here. His ability to acquire and hold, in the face of keen completion, a large practice among intelligent people is the best witness to his attainments in those varied and intricate accomplishments which mark the successful family physician.

To his medical associates Dr. Van Bibber was endeared by his courtesy in consultation, and readiness to take part in enterprises looking to the advancement of professional interests.

He will long be remembered by his patients as a faithful physician; a companion full of sunshine and humorous anecdote; and a sympathetic friend, whose kindness overflowed in service to the poor and the friendless of this great city. The troubles which gathered about him in recent years wakened a responsive chord of sympathy in many a heart which had been cheered and helped by his ministrations.

Medical Progress.

ACTIVE AND PASSIVE DESTRUCTION OF RED CORPUSCLES.

From a study of the character and distribution of blood pigment under different circumstances of health and disease I have been led to distinguish sharply two different processes in the blood, each of which may lead to a formation of blood pigment, and each marked by different changes in the red corpuscles.

The first of these is marked by a gradual decay of the red corpuscles. Retaining their form and their hæmoglobin to the last, they are ultimately taken up bodily by the active cells of the spleen or leucocytes of the blood and are stored up within the spleen or in the capillaries of the liver. Within these cells their hæmoglobin becomes transformed into blood pigment, and the pigment so formed is characterized generally by the varying size of its granules and by the largeness of at least some of them, corresponding in size, as they may do, to that of the original red corpuscle. It is this process that leads to the formation of the larger particles and clumps of pigment I have shown you in the capillaries of the liver in frogs, birds and mammals; and also in the spleen of old mammals and after transfusion. The particular point to be noted about this process is that the whole of the hæmoglobin of the corpuscle is converted into blood pigment and that the pigment so formed is never found within the liver cell. The conditions favorable to such a mode of death of the red corpuscle are for the most part negative. They are such as old age, abstinence from food, want of exercise—such, in fact, as necessarily imply a relative inactivity of the cells of the body, and therefore presumably a relative absence of any great changes in the other constituents of the blood—namely, the plasma and leucocytes. This change in the corpuscle implies an absence of any influences in the plasma of the blood likely to affect the red corpuscles injuriously. The *rôle* of the plasma and leucocytes in bringing it about is a purely passive one, and hence this mode of death of the red corpuscle may, as I have suggested, conveniently be described as a passive destruction of red corpuscles viewed in relation to the *rôle* taken in by the blood as a whole, or *chronic* viewed in relation to its slowness.

The second process is marked by a different series of phenomena. The first of these is a liberation of the hæmoglobin of the corpuscle. It is set free into

the plasma and may, as in the other case, likewise be taken up by cells of spleen or leucocytes of blood. If so, it is also converted into blood pigment; but this pigment can, as I have shown you, be distinguished broadly by certain features from that arising from passive destruction—viz., by the smaller and more uniform size of its individual granules. The usual fate of the hæmoglobin thus set free into the plasma is not, however, to be thus taken up by ordinary cells, but to be carried to the liver and to undergo within the liver cells a series of changes differing in details and in results from those that take place in ordinary cells. The chief result is a formation of bile pigments, not of blood pigment. A formation of blood pigment does not necessarily, in my opinion, attend the breaking up of hæmoglobin by the liver cell in mammals. It is in this respect that this proces *qua* the formation of blood pigment differs most materially from that of passive destruction. In the latter the whole of the hæmoglobin is thus transformed; in this process, on the other hand, none of it may be thus converted. This manner of disposal of hæmoglobin is not, as I have said, necessarily attended by a formation of blood pigment. If, however, it does occur, as it undoubtedly does both in health (birds and mammals) and still more markedly in disease (pernicious anæmia, action of poisons), only a part of the hæmoglobin molecule is converted into blood pigment, and the pigment so arising is distinguished by the features already described—namely, the small and uniform size of its granules. It is only pigment so formed that is found within the liver cell.

Such a liberation of hæmoglobin from the red corpuscles implies obviously certain conditions of plasma unfavorable to their preservation—in health, *e.g.*, digestion, and disease the action of poisons. The important point to recognize is that the liberation of hæmoglobin from the red corpuscle implies as surely the existence of changes in the plasma unfavorable to the red corpuscle as the gradual decay of the red corpuscle implies the reverse. The *rôle* of the plasma (and by implication also the leucocytes and other cells which control the constitution of the plasma) is thus as active as in the latter case it was passive, and hence, as I have suggested, this form of destruction of the red corpuscle may conveniently be described as an *active* destruction of red corpuscles viewed in relation to the *rôle* of the blood as a whole, or *acute* viewed in relation to its rapidity.

The foregoing expresses, then, the views I have formed regarding the two ways in which blood pigment arises. We are thus led to recognize that two diametrically opposed processes in the blood may lead to its formation, one of them the result of inactivity on the part of the plasma and leucocytes of the blood (passive destruction), the other as definitely marking the activity of these elements (active destruction). Since the object of our study is to ascertain what it is that affects the blood as a whole, and not any one particular element of it, it will, I think, be clear that the process which brings about what I have termed "active" destruction of the red corpuscles is the only one that is rightly entitled to be spoken of as hæmolysis, since it alone affects the blood as a whole. For, as I have shown, the process termed "passive" is unattended by change in the blood generally—marks, indeed, the absence of such change. It is the changes connected, then, with active destruction of red corpuscles that especially deserve our consideration. It will now be clear to you what a varying significance amount of blood pigment, apart from its character and situation, may have as an indication of hæmolysis; for it is passive destruction of red corpuscles that leads to the conversion of the whole of the hæmoglobin into blood pigment and its storage up in the body in this permanent form; while active

destruction, on the other hand, by causing its liberation into the plasma, favors its disposal and its removal from the body in ways—namely, by action of the liver cells—that are not necessarily attended by any formation of blood pigment at all.

The conclusion, then, is that hæmolysis may be unattended by the formation of any blood pigment, and hence it follows that the absence of such pigment in health in young mammals is quite compatible, as I will now show, with the occurrence of a very considerable daily hæmolysis.

Having thus made clear to you that the evidence to be derived from a study (1) of bile pigment and (2) of blood pigment both alike point to a certain destruction of hæmoglobin, and presumably therefore of blood, as an event of no uncommon occurrence, the question arises: What is the frequency or extent of this destruction in health?

Hitherto our knowledge on this point has amounted to this—that there is a close genetic relationship between certain pigments daily excreted from the body in the urine and bile and hæmoglobin; that blood pigment obviously derived from the blood is occasionally found in certain organs of the body; that the amount of this pigment varies very much under conditions as yet unknown; that when present it obviously points to a greater destruction of blood than when it is absent; that as its presence is not constant, even in the same animal, no conclusion can be drawn from it as to the frequency or constancy of a process of blood destruction; therefore that, on the whole, there is no reason to conclude that any destruction of blood takes place except under exceptional circumstances, such as malaria and paroxysmal hæmoglobinuria.—From an article by Dr. Wm. Hunter, of London, on "Blood Destruction," *Lancet*, December 3rd.

INTRAVENOUS INJECTION OF SALINE SOLUTION FOR HÆMORRHAGE.

This case illustrates the extreme simplicity of apparatus requisite for intravenous saline injections, and at the same time the value of its recent addition to our clinical powers. As, like most operations of emergency, it is pre-eminently a "general practitioner's" operation, its simplicity, and the fact that all necessary apparatus may be improvised from the most ordinary practitioner's stock, cannot be too strongly insisted on.

On September 27th, I was asked by my friend, Mr. C. Alford, to see with him a lady, aged 37, a multipara, whose last confinement, a twin, had occurred two years ago. She had miscarried on the evening of September 26th, being, as she reckoned, about three months pregnant. Whether the whole ovum came away is doubtful, as the discharge had not been preserved. There was much hæmorrhage, which continued until Mr. Alford had washed out the uterus with hot water. There had been further bleeding through the night, and when I saw her at 7.30 A. M., she was suffering from acute anæmia resulting therefrom. The pulse was 148, weak and thready, the face very pale, and lips blanched. She lay in a lethargic state with her eyes half closed, languidly moaning; the respirations were deep and sighing; at frequent intervals she vomited, invariably when she took any milk and soda water, Brand's essence, or champagne, all of which had been given her in small quantities. The uterine hæmorrhage had apparently ceased.

After a hypodermic injection of ergotine the same treatment was persisted in until noon, when I saw her again; she was then decidedly worse. There had been only slight uterine flux, but the frequent vomiting had persisted, so that she retained nothing. She was very restless, and the pulse was now quite uncountable.

At 1 P. M., she being in a condition of imminent danger, five pints of saline solution were injected into a vein at the bend of the elbow. I had no special apparatus at hand, but the following simple armamentarium was sufficient:—a lancet and a pair of dissecting forceps, a needle threaded with silk, a silver Eustachian catheter, the indiarubber tube from a feeding bottle, a small glass funnel, and the greenhouse thermometer. The solution was prepared with boiled water, of the approximate strength of one drachm of common salt to the pint. A tape being tied round the middle of the arm, the most prominent vein at the bend of the elbow was selected. This was readily exposed by pinching up the skin and transfixing with the point of the lancet. The vein was then dissected out and isolated for about half an inch of its length. The threaded needle was passed beneath it, and the silk cut at the eye, leaving a double ligature under the vein. These being drawn upon, untied, by an assistant, the vein was opened by a longitudinal slit, and the point of the Eustachian catheter inserted without the loss of a drop of blood. The distal ligature was now tied on the vein, while the proximal was also tied round the point of the catheter, which, on relaxing the tape on the arm, was filled with blood by reflux from the vein above. The funnel and tube were filled with the solution at a temperature of 99° F., the latter slipped over the large end of the catheter, and the solution allowed to flow. The five pints were introduced as quickly as possible, the patient rapidly improving meanwhile. The pulse at the end of the injection was 108, regular, and of fair volume. She shivered a good deal just at the close, but this passed off in about ten minutes.

There is little to add, except that her recovery from this time was uninterrupted. The vomiting continuing, she was for twenty-four hours fed by the rectum only. In the evening she was delirious, but she slept a good deal in the course of the night, and the next day was carefully fed by the stomach. She once unguardedly sat up in bed, and immediately fell back in a swoon. Steadily improving, she was able to go for a drive at the end of three weeks, there being at that time still a little œdema of the legs, which later disappeared with the anæmia.—Edward J. Cave, M. D., in *British Medical Journal.*

Correspondence.

WHAT IS NEEDED IN THE HEALTH OFFICE.

BALTIMORE, December 21st, 1892.

Editor Maryland Medical Journal:

Your remarks in the editorial column of last week's JOURNAL, suggesting the importance of some decided action on the part of the medical societies of Baltimore in reference to precautionary sanitary measures which should be forced upon our Health Department, are timely and of great importance to the public.

It is apparent to every thoughtful physician that our system, or rather want of system, in regard to the so-called "inspection" of contagious diseases is worse than useless; for it lulls the fears of the people of Baltimore, and gives them a partial sense of security which may at the appearance of an epidemic be suddenly torn away, exposing the inefficiency of the Department when it is too late to remedy it.

Let your readers know through your JOURNAL what we have got in the Health Department to start with. Give us the names, record, and evidences of sanitary knowledge and contributions to sanitary science by the *medical* officers of the

Department. Give us the names and record of the *non-medical* sanitary inspectors; and let us know what are the salaries and duties of these so-called inspectors. What do they inspect ? The patient ? If so, in what way do they contribute to the knowledge already gained ?

Would it not be better, in your opinion, to have this inspection done by well-educated young physicians who have a scientific knowledge of sanitary matters, etc.?

The daily papers—*Sun, American and News*—have lately published some valuable articles on sanitary matters; showing that they are alive to the importance of proper protection for the people of this city, and that they want and will insist upon something a great deal better than we have at present.

Let the medical societies take action at once.*

SUBSCRIBER.

Medical Items.

One of the best of Lawson Tait's axiomatic expressions is: "The road to success in the practice of our art lies not only in the knowledge how to deal with disease, but how to deal with men and women who suffer from it."—*Ex.*

A Section of Railway Surgery of the Pan-American Medical Congress has been organized with Dr. C. W. P. Brock, of Richmond, Va., as executive President. A full list of officers has been provided for each of the constituent countries.

The Bohemian Club for the Emancipation of Women has petitioned the Austrian Minister of the Interior to allow women to study pharmacology and to practise pharmacy, which in Austria is included among the learned professions. The Minister has not yet given his decision.—*Ex.*

According to the *British Medical Journal* a distinguished Vienna professor gives the following prescription to all young physicians who call to take leave of him before embarking on their professional career. ℞. Veritatis, humanitatis, fidelitatis, aa infinitum. Misce. Ft. elixir vitæ. Signa: To be used constantly throughout life.

We desire to call the attention of those among our subscribers who read Spanish to the authorized Spanish organ of the Pan-American Medical Congress, a handsome monthly publication entitled "*La Revista Médico-Quirúrgica Americana.*" It is published by the J. Shepherd Clark Co., 126 Liberty Street, New York. Its price is $3.00 a year.

To remove nitrate of silver stains from the fingers: A correspondent of the *Scientific American* gives the following harmless process: First paint the blackened parts with tincture of iodine; let remain until the black becomes white. The skin will then be red, but by applying ammonia the iodine will be bleached, leaving white instead of black stains of nitrate of silver.—*Ex.*

To the immense relief of the German nation, Weyl has shown that the consumption of beer can go on even if cholera is abroad, for unless the beer is artificially alkalinized he finds that cholera germs die out within twenty-four hours

*Further correspondence upon this important subject is solicited from public-spirited citizens, subscribers or non-subscribers, physicians or laymen.—Editor.

after being added to the beer. Where, however, the beer was sterilized and then alkalinized, the germs did not disappear for three days.—*Omaha Clinic.*

The Bureau of Hygiene and Sanitation of the World's Columbian Exposition has been organized to prepare a collective exhibit illustrative of the present condition of Sanitary Science.

The aim of the Bureau of Hygiene and Sanitation will be to show as adequately as possible the position in which the theory and practice of hygiene stand at the present day; and it is hoped that the universities and colleges, the boards of health, State and municipal, the societies having hygiene and sanitation as their key-notes, the scientists, the physicians, the manufacturers and the public generally will cordially co-operate in the endeavor to make the exhibition worthy of the science and of our country.

The daily press announces the death of Sir Richard Owen, the well-known English authority on comparative anatomy. After ten years of medical life, spent largely in London and Paris schools, he was honored at the age of thirty with the chair of comparative anatomy at St. Bartholomew's Hospital. Two years afterward he succeeded Sir Charles Bell in the chair of anatomy and physiology in the College of Surgeons. After twenty years of devotion to its duties he exchanged it for the charge of the departments of natural history in the British Museum. He was a voluminous writer on subjects connected with the above positions, and also upon fossil remains of man and animals.

No plan having been made by the Board of Directors of the World's Exposition for a Children's Building, and no funds having been appropriated for this purpose, the Board of Lady Managers feels it necessary to take up the work of building and equipping a beautiful structure which shall be devoted entirely to children and their interests. The Board has secured a desirable location adjoining the Woman's Building on which to build the Children's Home, but only on the condition that the necessary funds for erecting it be provided within sixty days. In the Children's Home will be presented the best thought on sanitation, diet, education, and amusements for children. Here mothers may leave their children, while they themselves go around and see things of interest to old folks. The children will be treated to kindergarten games; furnished with toys; with playgrounds where they may have games; with enclosures on the roof where they may fly kites, etc.; with reading rooms, etc. Donations to the Children's Home will be accepted from any source, and it is hoped that the young ladies in every community will feel that it appeals especially to them, and will assist the Board of Lady Managers in raising, at once, the sum which must be assured before the building is commenced. It is desired, also, that every child in America should feel a personal proprietorship in this building, and for that reason the Board would like to have a portion of the money for carrying out its plans contributed by the children themselves. Any child, or club of children, sending one dollar, will receive a printed certificate of acknowledgment, stamped with the official seal of the Board of Lady Managers. The Board trusts that its request will meet with a ready response from mothers, educators, and all those who love children. Contributions are strongly urged from all sources, and, owing to the limited time allowed for raising the required amount, it is imperative that all donations should be sent in at the earliest opportunity. Checks should be sent payable to Mrs. George L. Dunlap, Chairman and Treasurer of Children's Building Committee, 328 Dearborn Avenue, Chicago, who will give all desired information.

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Original Articles.

THE MORE COMMON FORMS OF NASAL STENOSIS.*

BY S. K. MERRICK, M. D.,

Professor of Diseases of the Nose, Throat and Chest, Baltimore Medical College.

Within the past decade our knowledge of morbid conditions in intra-nasal diseases have greatly increased, and the means for relieving or improving the same have correspondingly multiplied. While the literature of this subject has been voluminous (especially here in America), yet I feel sure there are many among the rank and file of the profession who do not fully appreciate the importance which attaches to the subject, and some who are even sceptical as to the etiological relation which the milder forms (at least) of nasal stenosis bear to catarrhal processes in the upper air-passages. I have therefore selected the title of this paper with the view of laying before the Society just such cases of nasal stenosis as are seen daily by the throat specialist and which cause the vast majority of the chronic catarrhs encountered. I shall therefore endeavor to confine my observations to the forms of stenosis, which, combined, far outnumber *all* others and in consequence are of prime importance to the *general* practitioner as well as to the specialist.

The deformed septum nasi ranks first in frequency as well as importance. I

*Read before the Medical and Chirurgical Faculty of Maryland, at Easton, November 15th, 1892.

will include in the term "deformed" all septums, whether simply deflected, both deflected and thickened, or simply thickened.

In order to give some idea of the frequency of this cause of nasal stenosis I quote the following from Bosworth: "Statistics by three authorities, aggregating 224 skulls examined, of which 70 per cent. had deflected septa. They were all dry skulls, and as their bones are often warped in drying, some allowance must be made for these cases.

"Zuckerkandl, who has perhaps made the most thorough study of this subject, bases his statistics on an examination of the cadaver, and affords, in consequence, more accurate data. In 370 crania examined, 123 symmetrical and 140 asymmetrical nasal septa were found.

"Lowenburg, after making several hundred examinations of skulls, says only about one case in seven has an absolutely straight septum in all its parts, while Sir Morell Mackenzie, in an examination of 2,152 skulls in the museum of the Royal College of Surgeons, found 1,657 cases of deflected septa in a greater or less degree. The dry skull here, as in those first quoted, shows about 70 per cent. of deflections, while a study of the cadaver brings the percentage down to 40 per cent."

"A study of the living subject gives us still further information, Heymann going so far as to state that ninety-nine per cent. of *all* cases examined will show deformities." Bosworth observes, "This would seem rather an extravagant statement. If we recognize only those deformities which give rise to morbid symptoms, certainly the percentage should be very much reduced."

A notable difference as regards race was observed by Zuckerkandl; out of 103 barbarous or semi-barbarous people, only 24 had asymmetrical septa. Mackenzie's observations confirmed this statement, as only 22.6 per cent. of symmetrical septa were found in the superior races. Harrison Allen also found in 93 negro skulls deformity only in 21.5 per cent.

It would be safe to say that probably 40 to 50 per cent. in the civilized races have deflected nasal septa to such an extent as to cause nasal stenosis to a morbid degree, and hence go far to explain the existence of many cases of chronic disease in the upper air-passages.

Deflected septa are either congenital or acquired. The congenital form is due either to acuteness of the palatine arch, as shown in the diagram, or to injury to the cartilaginous septum in the process of labor.

The first class of cases was first noticed by Trendelenburg and subsequently by many observers, but to none are we more indebted than to Jarvis, of New York, for a wider knowledge of this congenital malformation.

May 27th, 1885, Jarvis reported four cases in the same family, in a paper read before the American Climatological Association, showing conclusively that heredity and the highly-arched palate, as a consequence, were the cause of the deflected septum in a certain per cent. of cases. The large majority, however, of deflected or deformed septa are undoubtedly due to trauma. Every time a

child or adult suffers from nose-bleeding, the result of a blow on the nose, injury to the septum has resulted and may be the beginning of cartilaginous or bony spurs (if not actual deflection), and sooner or later causes a greater or less degree of stenosis, and corresponding morbid action in the neighboring tissues.

To describe the various classifications of the deflected septum, which have been made by writers, and the details of the numerous methods for correcting the same, would carry me beyond the limits of my paper; suffice it to say they are all necessarily surgical, and are, I believe, left almost exclusively in the hands of the specialists to put into execution; and it must be confessed that even the most skillful operators, in not a few cases, fail to achieve complete and lasting results.

Hypertrophy of the turbinated bodies, the result of hypertrophic rhinitis, is an exceedingly common form of nasal stenosis, the condition being often accompanied or caused by deflection of the septum. There are two varieties of hypertrophy—the *false* and the *true*. The former is due to hyperæmia of the erectile tissue, and is generally temporary when associated with acute coryza; but it is not infrequently seen as a chronic affection, and due to some disturbance of the vaso-motor influence. When associated with hyperæsthetic rhinitis (as it very commonly is) it is often difficult to deal with. Indeed, complicating many cases of chronic nasal catarrh, it is not always easy to get rid of.

This form (*false* hypertrophy) is differentiated from *true* hypertrophy by its yielding to pressure from the probe much as a bulb of an ordinary atomizer does to the fingers, quickly resuming its former shape when pressure is removed. The true hypertrophy, on the contrary, causes such a consolidation by inflammatory thickening of the turbinates as to render them only slightly yielding to pressure and they recover sluggishly from the impression made.

The means for the relief of stenosis caused by hypertrophy of these bodies are essentially surgical (as in nearly all forms of nasal obstruction) sprays of one kind or another coming in only as adjuncts. In the false variety, however, occasionally a cure may be effected without surgical interference, but most authors advise superficial cauterization with the side of the blade of the electrode of the galvano-cautery. I have generally myself been forced to this procedure in most cases of false hypertrophy and the use often of strychnia, iron and other tonics before satisfactory results could be attained.

It is generally conceded that the most satisfactory method of destroying true hypertrophy is by the galvano-cautery, yet the cold-wire snare, chromic acid and even nitric acid have their advocates.

In posterior hypertrophies I have generally used the Jarvis snare, but recently I have been using the galvano-cautery through the posterior nares and have been pleased with the results.

The catarrhs which are a result or accompaniment of stenosis will not be cured until proper drainage and aeration of the intra-nasal tissues are accomplished facts.

Occasionally practitioners mistake large hypertrophies for polypi, but this is comparatively infrequent, as they possess many points of difference, and are easily recognized by those accustomed to rhinoscopic work.

Polypi next claim our attention as a cause of nasal stenosis. There are three varieties which may be found in the nose, viz.: Myxomata, fibro-myxomata, fibromata. But the first is the only one which is common, hence it only has a claim on our attention.

Myxomata are the well-known mucous or gelatinoid polypi so often encountered and not infrequently associated with chronic bronchitis and asthma. They almost always spring from some one or more of the turbinates, become pediculated and are seen on illumination, or indeed occasionally protruding from the nostril, as pendulous, translucent, jelly-fish-looking rounded bodies, and cannot be mistaken for any other neoplasm which grows in the nose.

These growths should always be removed by means of the cold-wire snare if possible and the stump freshly cauterized with the galvano-cautery electrode.

This growth is prone to recur and I mention the above method of getting rid of the growth because I think there is less liability to recurrence when this method is carefully carried out than is the case with any known means for its destruction.

Bosworth believes that whenever fibro-myxomata occur in the nose they are always the result of wounds and lacerations of myxomata, caused generally by the forceps, which were a few years back much used.

The galvano-cautery loop is well adapted to the removal of these growths in favorable locations, but it cannot be manipulated with the same facility in the deeper parts of the nasal fossa as the cold-wire snare, and in consequence has a more limited field of usefulness in these cases.

The degree of stenosis occasioned by these growths varies within wide limits—from the slightest interference with nasal respiration to complete occlusion of both nostrils. I have a case now undergoing operations once a week (after the above method) who when he presented himself for treatment was unable to force any air through either naris. Patients so afflicted will have dry, parched throats from mouth-breathing and in those at all predisposed sooner or later follow morbid processes in the bronchial tree.

Another very common cause of nasal stenosis in childhood (until the age of puberty), is adenoid vegetation at the vault of the pharynx. Few practitioners who have not especially investigated this subject are aware of the extreme frequency of this affection. The chronic nasal catarrhs so common in childhood are probably more frequently occasioned by these vegetations or hypertrophies of the adenoid tissue at the pharyngeal vault than by all other causes combined. This diseased condition was first accurately described by Wilhelm Meyer, of Copenhagen, yet Czermack had recognized it as early as 1860, although he failed to recognize its clinical importance. Lowenberg, J. O. Roe, Bosworth, B. Frankel, Chatellier, Hooper and others have since contributed to our clinical knowledge of the disease.

When nasal stensis results from this cause the voice is said to be "dead." When the patient is made to pronounce the consonants *m* and *n* they are pronounced *eb* and *ed*. The bridge of the nose becomes broadened in the several forms and the nasal bones may become separated until a conspicuous facial deformity results known as "frog-face."

These growths are removed by either the post-nasal cutting-forceps curette, cold-wire snare, cautery loop or galvano-cautery puncture, according to the size, form and vascularity of the tumors.

843 N. Eutaw Street.

THE TREATMENT OF ISCHIO-RECTAL ABSCESS.*

BY HENRY R. WHARTON, M. D.

I have been requested to say a few words this evening on the treatment of ischio-rectal abscess and fistula in-ano to open the discussion upon these subjects by the members of this Society.

Treatment of Ischio-rectal Abscess.—In this form of abscess the purulent matter occupies the loose cellular tissue of the ischio-rectal fossa in close relation to the rectum, and from the anatomical peculiarities of the tissue in which it is situated it is apt to burrow widely and, if left to itself, to open into the rectum or through the skin into the region of the anus, and result in the production of one or other forms of fistula-in-ano, either the complete form or the external or internal incomplete form of this affection.

To obviate this unfortunate result the prompt treatment of ischio-rectal abscess is urgently demanded, and I am decidedly of the opinion that attempts at abortive treatment of this form of abscess are worse than useless, that by such treatment valuable time is lost, and the surgeon has finally to resort to surgical treatment after extensive burrowing of pus has occurred with possibly perforation of the wall of the rectum.

It is, and has been for a long time, a surgical axiom that an ischio-rectal abscess should be opened promptly, and if so treated the probability of a fistula-in-ano resulting is much diminished. I formerly was satisfied to open these abscesses by a small incision, evacuate the pus, and in many cases a prompt recovery took place without the formation of a fistula, but in others a fistula resulted; whether the rectal communication was present at the time of opening or resulted from the imperfect drainage secured by a small incision I am unable to say, but I am sure that the results I have obtained in these cases during the last few years since I have adopted Mr. Allingham's method of dealing with these abscesses have been much more satisfactory. By this method of treatment, even in cases where I have been able to demonstrate a rectal communication at the time of the operation, I have secured healing without the formation of a permanent fistula. Therefore, in any case of inflammation of the tissues of the ischio-rectal fossa,

*Read before the Philadelphia County Medical Society, November 23, 1892. The portion which treats of fistula-in-ano referred to is given under "Miscellany" in another number of this JOURNAL.

whether the evidence of abscess be clearly demonstrated or not, I follow the method recommended by Mr. Allingham, which consists in etherizing the patient and placing him in the lithotomy position after having located the position of the indurated tissue or abscess; and a rectal examination by means of the finger will often assist in locating the position of the abscess. A free incision, several inches in length, is made through the tissue, outside and parallel with the fibres of the external sphincter muscle, and the incision is gradually deepened until the pus cavity is reached. It is then slit up to the length of the skin incision and the cavity is explored with the finger, breaking down any loculi which tend to divide up the abscess cavity, and so make one cavity of the abscess. The cavity of the abscess is next washed out with a 1:2000 bichloride of mercury or 1:60 carbolic acid solution and is then packed with strips of iodoform gauze, and a pad of the same gauze is placed over the wound, and over this a pad of bichloride of mercury cotton is laid, and the dressing is secured in position by a T-bandage. An opium suppository is introduced into the rectum and the bowels are kept quiet for three or four days.

The dressing is not removed for two or three days, and at this time the packing is usually loose and can be removed without difficulty, and after its removal the cavity is injected with peroxide of hydrogen, and it is then irrigated with a 1: 2000 bichloride of mercury solution, and next the cavity is lightly packed with strips of iodoform gauze and bichloride cotton. The same steps are observed at subsequent dressings, which are made at intervals of two or three days, and the cavity usually heals rapidly by granulation and contraction, and in a few weeks it is usually completely healed.

Mr. Allingham recommends that the cavity be packed with lint saturated with carbolized oil, and I have employed this material, but now prefer to use the iodoform gauze, as I stated above.

I will report briefly a case in which this treatment was adopted. In January of this year I saw, with Dr. Musser, a lady forty years of age, who had suffered for a few days with inflammation of the tissues of the ischio-rectal fossa. On examination of the case I found the left buttock, for a distance of six or eight inches from the very verge of the anus, indurated, hot and painful; no soft spot of pointing could be detected. An examination of the rectum showed bulging of the walls of the rectum in the left side, and upon withdrawing the finger a small amount of pus escaped from the anus. The patient also stated that some matter had been discharged from the rectum during the day. The patient was etherized and a curved incision four inches in length was made just outside of the line of the sphincter muscle. This was gradually deepened until the cavity of the abscess was opened and a free discharge of pus, many ounces, escaped. On introducing my finger I found that the cavity extended laterally for some distance and passed upward between the wall of the rectum and the sacrum. In fact, with my two fingers introduced to their full length in the wound I could not reach the upper portion of the abscess cavity. A careful examination failed to

reveal the position of the opening into the rectum. The abscess cavity was thoroughly irrigated with a 1 :2000 bichloride of mercury solution and was then packed with strips of iodoform gauze, and a pad of gauze and bichloride cotton was placed over the external wound and held in place by a T-bandage. The patient did well after the operation and the cavity was dressed in the same manner every second or third day for the first two weeks, and at less frequent intervals after this time for six weeks, at which time healing was complete.

There is no question in my mind that there existed a communication between the abscess cavity and the rectum before the operation, as was shown by the discharge of pus and by the discharge from the wound about a week after the operation of a piece of bone a little larger than a grain of corn. This bone Dr. Harrison Allen examined for me and pronounced it to be a portion of a transverse process of sheep's vertebra. It had been swallowed with the food and had ulcerated through the wall of the rectum, and had set up inflammatory action in the peri-rectal cellular tissue, terminating in this extensive abscess.

The points in the treatment of ischio-rectal abscess I would especially call attention to are: Early and free incision; thorough breaking down of any secondary abscess cavities into one cavity; irrigation of the cavity with peroxide of hydrogen and a 1:2000 bichloride of mercury solution or 1:60 carbolic acid solution; packing with iodoform gauze and subsequent dressings made in the same manner, care being taken not to pack the cavity too firmly. Following this form of treatment the results of this variety of abscess in my hands have been most satisfactory.

Society Reports.

TRANSACTIONS OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

SECOND ANNUAL MEETING, HELD IN NEW YORK, OCTOBER 4, 5 AND 6, 1892.

FIRST DAY, OCTOBER 4, EVENING SESSION.

Dr. R. J. Nunn, of Savannah, Ga., read a paper on STABILE ELECTRODES. OLD METHODS NEWLY ARRANGED.

The author said that for high tension currents moisture is essential, and the best electrode would be one which, while convenient to handle, would at the same time bring the largest amount of water in contact with the skin. The electrode which he had devised is made out of forty or fifty pieces of lint, cut of the desired size, and made into a pad about one and a half inches thick when wet. The pieces are held together by a loose stitch. If the stitch be drawn tightly, an indentation will be produced which is not desirable. It is better to cover the pad with chamois leather. The whole is very thoroughly wetted, and connection is made through a large and very pliable metal plate. If the pad be pressed firmly against the skin by means of a bandage, a larger amperage may be employed.

DISCUSSION.

Dr. Massey had not yet found an electrode equal to one properly made out of

fine white China clay. The alkalinity of the clay was also an advantage, as it lessened the resistance of the electrode itself. He had also gotten good results from pads of thin cheese-cloth, with some elastic material like cotton or wool. Instead of using a metallic plate, he employed a flat wire spiral. There is a decided difference in the sensation with even the best electrode, if the surface be well moistened with a good *lather* of soap.

Dr. Mosher, of Brooklyn, New York, said she wished again to speak of the advantages of her Indian meal electrode. The softer variety of meal is cooked, and placed while hot in a double cheese-cloth bag of the size of the metal plate, and then this "poultice" is applied to the abdomen a few minutes before the introduction of the internal electrode. If pressure be desired, a small sand-bag is laid upon the electrode. With this device a very heavy current could be employed with but little discomfort to the patient. Where lighter currents were used she employed an electrode made out of from four to ten layers of cotton flannel, placed evenly over the surface.

Dr. Anna M. Galbraith, of New York, said that in the Orthopedic Dispensary she was accustomed to use wire gauze, wrapped up in a number of pieces of flannel and fastened tightly to the part by a belt.

Dr. Goelet thought he had solved the problem of the clay electrode. The clay is first made into a flat cake, then covered with "lintine" (compressed cotton-batting), then covered with gauze, and backed with sheet rubber. This electrode is thoroughly wetted, and placed over a zinc vessel, containing warm water, and is kept here until wanted. Such an electrode can be washed off with soap when soiled as readily as the hands and can be bleached when necessary with peroxide of hydrogen. It is always neat and clean.

Dr. W. F. Robinson, of Albany, said that for currents of mild intensity he had found nothing equal to the wire gauze, covered with flannel, or with cotton-batting.

Dr. Rockwell kept the clay in a large mass, having a hole in the centre filled with water. When wanted for use, a portion is taken, kneaded well, wrapped in a towel, and rolled to the proper size. Where currents of over 100 milliamperes are required, this electrode should be covered with gauze or tarlatan, and in winter a warming-pan should be used.

Professor Houston suggested that the addition of graphite would greatly increase the conducting power.

Dr. Massey was not favorably impressed with this suggestion, because it would make the electrode very dirty, and, more particularly, because it would make the transfer from metallic conduction to skin conduction too sudden. He covered the clay with a lead plate cut in the shape of a Maltese cross, and where there were scratch marks, or pimples, this portion of the plate was raised. The most perfect electrode probably would be a piece of fresh meat.

Dr. Mosher used a glass microscope slide, which she slipped in between the plate and any specially sensitive spots.

Dr. Nunn, in closing, said that he had found the electrode he had described more convenient for office work than the clay. The object of the chamois leather was to take the place of an animal membrane. Where there were scratch marks or sensitive spots, he protected these with bits of rubber tissue.

THE VALUE OF VOLTAIC ALTERNATIVES IN OPTIC NERVE ATROPHY, by Dr. C. Eugene Riggs, of St. Paul. (Read by title.)

Dr. W. F. Robinson, of Albany, read a paper on SOME PHASES OF NEURASTHENIA, AND THEIR TREATMENT.

The paper was devoted chiefly to a consideration of *cerebral* neurasthenia. In this form, *depression* is the prominent symptom, and furnishes the key-note to the treatment. The author thought that neurasthenia could be better treated by galvanism and Franklinism than by either one alone, but he did not wish to be understood as advocating electrical treatment to the exclusion of all other therapeutic measures. He laid special stress upon the importance of a general systemic action of the current, and of separating the poles widely, so as to secure proper diffusion of the current. He usually began the treatment with the static charge, employing it for about three minutes at each sitting. In occasional cases static electricity either has no effect, or else produces unpleasant symptoms, such as dizziness and headache. Where galvanism is employed, five to ten milliamperes may be used to the spine daily. The constant current should be used at the beginning, as being less irritating; later on, one can safely pass to the interrupted current, which is one of the best of vital stimulants.

Dr. Massey said that in considering the treatment of neurasthenia, one should never forget the important part played by the alimentary canal. After commenting upon the good effects which he had seen follow the employment of the laborious Weir Mitchell method of treatment by faradization of individual muscles, he said, that he had found the treatment could be generally shortened and simplified and with equally good results, by having the patient lie on a large positive electrode, and then, with a current sufficient to cause vigorous contractions, rub the negative electrode all over the accessible portions of the body.

Dr. Rockwell said that the author had cautioned against sudden changes, yet he advised going from the static electricity to galvanic electricity. These two forms were as far removed from each other as possible; the faradic current would have been an intermediary one, and where systemic effects are desired, he thought the faradic current gave the best results.

Dr. Hutchinson did not approve of the very small dosage advocated in the paper; the current should be as strong as can be used and should be applied near the nerve centres. All workers in this field were endeavoring to secure the *systemic* effects, and while the results were good, the treatment was very slow.

Dr. Galbraith remarked that she had a lady patient, who had previously submitted to the Weir Mitchell treatment, but found the treatment by galvanism much more pleasant.

The President said that the author had been so cautious in his dosage as to almost tell us how *not* to give electricity. Personally he always felt he could not give enough, and that the skin was the chief barrier to success, because it limits the strength of the current that could be employed.

The Association then adjourned in order to accept the invitation of the Electric Club to a reception.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD NOVEMBER 28TH, 1892.

Meeting called to order, Dr. Waters in the chair. Minutes of previous meeting read and approved.

Dr. Ashby related a case: Lady came under his care; eight years married, no children; had slight anteflexion, but did not think it sufficient cause for sterility. He thought he could feel a prolapsed ovary in the left side, or a tumor; dilated uterus with large sound. Next period came on, pain just as severe; he dilated

again and advised her to go home and wait for pregnancy. She did and in five months pain was just as severe. Great sufferer, would remain seven days in bed; was badly constipated. He then decided upon a laparotomy; he removed the left ovary; had found it had undergone cystic degeneration. Left the right one intact; recovered from operation without any bad symptoms; heard from her recently and she was in her eighth month of pregnancy. I mention this case because the diseased ovary had debarred her from pregnancy.

Dr. Chambers: I am glad to see the gynæcologist taking a sensible view of laparotomies. It has been the custom every time the abdomen is opened to remove both ovaries. It is of no more use to remove both ovaries than to take out both testicles when only one is diseased; I do not think a simple ordinary cyst should cause removal of the ovaries. Does it?

Dr. Ashby: No. I would have drained it. I think Dr. Chambers' criticisms perfectly proper. There are some cases in which we remove normal ovaries, but that is done to bring about artificial menopause. I agree we have gone too far and it is time to halt. There is no doubt but what the diseased ovary is the cause of a great deal of mental trouble. The tendency now, I think, is in the right direction.

Dr. Chambers: I took same position several years ago at a medical meeting and I remember that Dr. Ashby agreed with me then.

Dr. Reid: I think Dr. Ashby should be congratulated. The question is: Is the credit of calling a halt due to the gynæcologist or the general practitioner? Everything carried to an excess will have a reaction. I think general practitioners should have some credit, as I have been fighting it for thirty years.

Dr. Chambers related cases of FOREIGN BODIES IN BLADDER, and exhibited specimens. First case: A thirty-two caliber bullet had passed the abdominal wall into bladder and passed out urethra. Second case: A ring pessary had been left in vagina; had ulcerated throughout vagina walls into bladder. Third case: Sea-tangle tent had been introduced through the urethra by the patient, thinking she was putting it in the uterus, to bring on an abortion. All covered with phosphates except bullet; supra-pubic operation was done.

Dr. Ashby said he had had a little experience with female bladders, but had a case of which he had removed five molar teeth by dilatation of urethra. Literature shows that women put more foreign bodies in their bladder than men. Urethra is so much shorter and not so difficult to do, and the bladder is in such close relation to vagina. He had rather remove per vaginam and make vesico-vaginal fistulæ, as they close very rapidly; if a small body, prefers dilating urethra.

Dr. Reid thought dilatation of urethra the best method.

Dr. Blake thought left lateral lithotomy the best and recited case of Hon. James Hodges.

Dr. Chambers agreed with Dr. Ashby. These things happen with women more than men. Self-abuse to bring on abortions. Some have such a small urethra it would be impossible to dilate.

Supra-pubic cystotomy has a very slight mortality. The condition of kidney and bladder have more to do with the results than the kind of operation you do. The manipulations if long in the bladder are all dangerous.

The Executive Committee were instructed to have the banquet in the hall. Adjourned.

EDWIN GEER, M.D., Rec. Sec'y.

1534 Park Avenue.

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A. K. BOND, M. D., Editor.

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BALTIMORE, DECEMBER 31, 1892.

Editorial.

THE NEW YORK QUARANTINE OF 1892 REVIEWED.

The report of the Chamber of Commerce of New York City, by its special committee on quarantine, was made public early in December. The report was presented by Mr. Seth Low, president of Columbia College, and was largely the product of his pen. The report is a voluminous one and is an *exposé* of numerous defects inherent in that form of State quarantine which obtains in New York Harbor. The report is not intended as a personal arraignment of the Health Officer of the port so much as it is an advocacy of a better and more scientific system of port protection. It calls upon the citizens to make a strenuous effort to at once have inaugurated a system of Federal quarantine. Not only the humane intelligence and sympathy of the community, but the interests of business and economics all point the same way—namely, to the abolition of local systems, with their myriad picayune entanglements, and the substitution therefor of a strong and modernized plan suitable to a great and growing nation. To meet the imminent dangers of the coming summer, in respect of cholera, the only efficient and safe protection appears to lie in a national quarantine, strongly supported by the respective States whose ports of entry are a menace to the whole country. The people at large will trust such an organization, whereas they distrust the weaker form of local protection accorded by State quarantines. In support of this statement, we might quote at length from the New York papers, but one paragraph from the *Herald* will suffice to show the prevailing tendency of thought. The *Herald* says:

"Quarantine is the last matter in the world that should be left subject to the abuses of politics, and least of all Tammany politics. It is a matter which involves not only the public health, but also the entire industrial and commercial interests of the community. To say nothing of its human victims, an epidemic in New York would entail business losses which it would take millions of money

and months of time to make good. Hamburg is still shunned and will long suffer in consequence of the scourge of last summer. Our own merchants will recall the great injury to trade in this city caused by even the menace of cholera in September.

"The pressing need of the metropolis is, therefore, the most efficient and the safest quarantine that can be devised. That this is not to be expected from a State quarantine under Tammany control is shown by recent experience. The well-known citizens who have signed the Chamber of Commerce report speak very mildly when they say this city did not enjoy the quarantine of the high scientific character that the country had a right to expect. The fact is, as everybody knows, we had no quarantine system at all worthy of the name. Thanks to the co-operation of the Federal authorities, the help of the Chamber of Commerce and the aid of public-spirited citizens, the metropolis escaped an epidemic. But this was due more to good fortune than efficient administration."

The only outspoken objectors to a national system who have declared themselves have been those who are friendly to last year's failure, or only partial success.

But to return to the report of the committee, the following statements are worthy of a medical audience:

"The committee are inclined to admit the contention that the Health Officer of the port is not to be held wholly responsible for the inadequacy of New York's preparations to cope with the cholera when it appeared in this port on the Moravia, August 30, 1892, though they are bound to say the plea would be stronger if there were any evidence to show that he had made persistent effort to increase the equipment, and had failed because of his inability to arouse either the authorities or the community to a sense of the danger and the need. He might not have succeeded, but it seems to the committee that it was clearly his duty to have tried. It is not unreasonable, however, to claim that the equipment actually on hand should have been in a state of utmost readiness.

"Your committee does not wish to enter upon a direct criticism of the recent quarantine at New York. They are familiar enough with the difficulties that had to be contended with to understand how hard it would be to be entirely just. They point out, however, to whatever circumstances it may have been due, that this city did not enjoy a quarantine of the high scientific character that the country had a right to expect. Such a quarantine would remove passengers from infected ships instantly and separate them into groups; adopt definite and proper methods of inspection and treatment of their baggage; release all passengers, except from such groups as developed fresh infection, within at most five days, and return the ships themselves to the uses of commerce, after a complete disinfection of both ship and cargo, assuming proper appliances to be at command, within an interval of from two to ten days, according to the size of the vessel and the character of the cargo. Your committee claim that this standard ought to

have been reached, for nothing short of the best is reasonable in connection with the first city of the United States.

"In view of the probability of a renewal of the cholera visitation in the spring the Chamber ought to demand that in the meantime the quarantine establishment at New York be equipped and organized so as to be ready to deal adequately with any emergency. The quarantine authorities, whether State or Federal, will justly be held to a strict account if a second time the quarantine at this port falls short of the highest scientific standard. The comfort and perhaps the lives of many thousands of people, untold losses in the interruption of business and the good name of the United States before the civilized world, all are involved.

"Your committee, therefore, are clear that the recent quarantine experience of New York points with singular emphasis to the importance of a national quarantine. They would sum up the arguments in its favor, as drawn from this experience, as follows:

"1. The Federal government being an indispensable factor in every quarantine crisis, it is only by giving to the Federal government complete control that conflicts of authority and the weakening effects of official jealousy can be avoided.

"2. The Federal government, in every crisis, through the various arms of the public service, is able to command an amount of expert co-operation entirely beyond the reach of a State Department.

"3. The Federal government has at command the trained men who have to be summoned to the help of the State in time of peril. It is better to have the Federal government directly responsible, instead of indirectly.

"4. To these may be added the further consideration that the co-operation of consuls with the quarantine officials is a matter of growing importance. The Health Officer complains that he failed to receive the aid from this quarter to which he was entitled. It is clear that these officers would be less likely to be at fault as toward Federal officials.

"5. An international supervision of infectious diseases is a probable and a very desirable outcome of recent experiences. Such an outcome of itself would necessitate a national quarantine."

THE WASHINGTON COUNTY MEDICAL SOCIETY.

In response to a request for information concerning the foundation and present status of this society, the Recording Secretary, Dr. Onderdonk, has kindly sent us some details which will be of interest to many, if not all, of our readers.

Many years ago there existed a county society in Washington County, but for some reason or other it lacked vitality and ceased to exist. For some years there was no bond of union among the local practitioners. The State Faculty confined its interests chiefly to Baltimore City, making no successful effort to stimulate society activities in the counties. The establishment of the present society in Washington County is due to the awakening of the Faculty to its true destiny as a State and not a city society, and to its efforts to carry out this aim by holding semi-annnal meetings at various points outside of Baltimore.

In pursuance to a call by a committee appointed by the Medical and Chirurgical Faculty of Maryland, the physicians of Washington County met at Hagerstown, Md., on December 16th, 1889, and reorganized the Medical Society of Washington County, adopting the constitution and by-laws of the society organized in 1866 as the basis of the constitution and by-laws of the new organization. At this meeting officers for the year were elected as follows: Dr. N. B. Scott, President; Drs. William Ragan and E. T. Bishop, Vice-presidents; Dr. J. W. Humrichouse, Corresponding Secretary; Dr. E. M. Schindel, Recording Secretary; Dr. O. H. W. Ragan, Treasurer.

The objects of the Society are: The separation of regular from irregular practitioners of medicine. The association of the profession *proper*, for purposes of mutual recognition and fellowship. The promotion of the character, interests and honor of the fraternity, by maintaining the union and harmony of the profession in the county, and aiming to elevate the standard of medical education. The cultivation and advancement of the science by united exertions for mutual improvement and by contributions to medical literature.

The Society holds its meetings in Hagerstown on the second Wednesday in January, April, August and November. Until August, 1892, the Society was dependent upon the courtesy of the authorities in control of the County Court House for a room in which to hold its meetings, but it has now secured permanent and pleasant quarters by renting a room from the Young Men's Christian Association.

At each meeting papers are read by one or more of the members, and frequently by gentlemen who are not members, in response to invitation. It is usual at each meeting for the President to assign for the next meeting a topic for general discussion.

The officers of the Society for 1893 are: Drs. A. S. Mason, President; A. G. Lovell and J. McP. Scott, Vice-presidents; H. U. Underdonk, Recording Secretary; E. M. Schindel, Treasurer; J. W. Humrichouse, Corresponding Secretary.

The members are: Drs. C. L. G. Anderson, H. K. Derr, J. W. Humrichouse, H. S. Herman, A. S. Mason, J. H. Maynard, C. McCauley, J. E. Pitznogle, O. H. W. Ragan, C. R. Scheller, E. M. Schindel, J. McP. Scott, N. B. Scott and T. W. Simmons, of Hagerstown; R. J. Duckett, of Bakersville; A. G. Lovell, of Benevola; J. M. Gaines, H. McGill Wade, W. B. Wheeler, W. C. Wheeler, and S. K. Wilson, of Boonsboro; J. M. Steck, of Chewsville; Abraham Schank and H. C. Foster, of Clearspring; H. U. Underdonk, of College of St. James; U. M. Richard, of Fairplay; W. M. Nihiser, of Keedysville; J. H. Wishard, of Leitersburg; E. C. Kefauver, of Mechanicstown; C. D. Baker, of Rohrersville; S. H. Gardner and E. J. Waddy, of Sharpsburg; C. A. Baldwin and E. Tracy Bishop, of Smithsburg; also C. R. Miller, of Mason and Dixon, Pa.

This is certainly a very promising association, and we wish it every success. At our earliest opportunity we will present to our readers the minutes, now in our possession, of its last meeting.

Medical Progress.

PARASITIC PROTOZOA IN CANCERS.

Writing in the *British Medical Journal*, November 5th, Dr. Armand Ruffer gives a further account of the studies in the causation of cancer. He says:

In our first note, as well as in our paper published in the *Journal of Pathology*, Mr. Walker and I stated that we were unable to find parasites in the nuclei of cancer cells. In this we agreed with all other observers, but since then I have seen the intranuclear stage of the parasite, and it is of these recent observations that I now wish to say a few words. I first saw this intranuclear stage of the parasite in carcinomata of the breast, and the most numerous instances of it were found in an extremely soft and fast-growing cancer removed by Mr. Christopher Heath from the breast of a middle-aged woman. Pieces of the tumor were at once plunged into each one of the following hardening reagents: (1) absolute alcohol; (2) alcohol 1 in 3; (3) 3 per cent. chromic acid solution, to which a few drops of formic acid had been added (Rabl); (4) Fol's solution; (5) Fleming's solution; and (6) 1 per cent. osmic acid solution. Of all these pieces, those fixed with Fol's solution and with 1 per cent. osmic acid revealed the presence of the intranuclear parasites best, whilst the other fixing fluids gave but poor results, even with the most varied methods of staining. In osmic acid preparations, indeed, the intranuclear parasite was well seen, even without the use of any coloring reagents, and could easily be demonstrated with hæmatoxylin, and more especially with Ehrlich's hæmatoxylin. The same result was obtained in other carcinomata fixed in the same manner.

The parasites first appear in the nucleus of the cancer cell as hard, dark-staining, small, spherical bodies, almost indistinguishable from the nucleolus of the cell. They scarcely ever occur singly, but are found in groups of two, three, or more, and I have seen over 20 of them in the same nucleus. The nucleus, when filled with these spores, appears as a hard, dark-brown mass with irregular outlines.

In a further stage the organism becomes transparent, and still later a dainty small nucleus appears in the centre of each parasite, the surrounding capsule at the same time becoming distinct. The nucleus of the cancer cell is then often filled with these small bodies, each showing the capsule and little nucleus above mentioned, though the rays present in the fully developed organism are not often met with in the young parasite. Not infrequently, however, one of the parasites increases at the expense of its fellows and becomes much larger than the others.

The parasite, or parasites, now gradually approach the periphery of the nucleus, and make their escape into the surrounding protoplasm. Every stage may be seen, sometimes even in the same section, from the time when the parasitic organisms are in the interior of the nucleus, passing through the stage when they are partly in and partly out of the latter, to the stage when they escape into the protoplasm of the cancer cell. At the same time the parasite gradually increases in size.

When the nucleus is absolutely crammed with parasites one side of it gives way; it bursts like any other parasitic cyst filled with spores, and its contents are discharged into the protoplasm of the cancer cell. Such a nucleus generally perishes, though this is not the case with the nuclei containing one or two parasites only. These generally appear to heal up perfectly, and present a good field for the study of a subject absolutely unexplored hitherto—namely, the process of repair of an injured cell.

I have now, therefore, seen every stage in the life-history of the protozoa of cancer, from the time when the parasite appears as a spore in the nucleus to the time when it leaves the latter as a young, fully-formed parasite. The other stages in the life-history of the parasite are still obscure, but I have hopes that this problem will now soon be solved.

LIPOTHYMIA.

In the Bradshaw Lecture, Dr. Gee refers thus (*Lancet*, November 12) to one of the symptoms of acute peritoneal diseases:

I will next speak of that marked failure of the vital functions (that is to say, of the circulation, respiration and body heat) which very often accompanies peritonitis. It is a matter for surprise and regret that we have no term in common use to express this set of symptoms. No English word being precise enough, I suggest that we resuscitate the Greek word "lipothymia" to denote *defectio animæ*, this failure of the vital constitution, whether it be attended or not by lipopsychia, *defectio animi*, or failure of the animal constitution marked by coma, delirium, or both. Sudden lipothymia is syncope or swooning; syncope due to injury is shock. Lipothymia is manifested by a small, weak and sometimes irregular pulse, by weakness of the heart sounds, by shallow breathing, by lividity with pallor (deathly paleness), and by algidity or failure of the body heat—at least so far as the skin is concerned; the inner heat, as measured in the rectum, may or may not fail to a proportionate degree. In peritonitis (apart from perforation) lipothymia sometimes marks the whole course of the disease (witness the Wandsworth epidemic, to which I referred a short time since); and when to lividity, coldness of skin and a weak, small pulse are added diarrhœa, watery stools and suppression of urine, the resemblance to cholera is great indeed. But more frequently lipothymia occurs only towards the end of life, and then it may assume, so far as the body heat is concerned, the form of lipyria (another ancient word which might be revived with advantage)—that is, while the skin, especially of the limbs, is quite cold, the temperature of the inward parts, as measured by a thermometer in the rectum, is much above the normal; it may be 105°—a very bad prognostic sign in all acute diseases, and a plain proof of the extreme weakness of the circulation. Another sign which sometimes attends this final lipothymia—this mortal agony or struggle with death—a sign which has attracted the notice of physicians from the earliest times—is the disappearance of pain and suffering whilst the patient remains perfectly conscious; yet all the symptoms of vital failure persist, and he only whose attention is fixed upon the local signs to the neglect of the prognostic condition of the whole patient can be surprised by what will seem to be a sudden and unexpected death. It were curious to inquire into the causes of this cessation of pain, whether it be due to cessation of cramp, whether an anodyne poison be produced in the course of the disease, whether the lipothymia arrests the nutrition of the nerve endings, or whether the sensorium for pain be similarly affected; but I will say no more than to remind you, Sir, that an honorable predecessor of yours in that honorable chair—Sir Henry Halford—once read before the College an essay dealing with this very topic. Still more remarkable

although much less common, is the case of peritonitis attacking a healthy person, lipothymia supervening in the course of a few hours from the beginning, and any local signs of abdominal disease disappearing at the same time. The patient when first seen makes little or no complaint of the abdomen; it is not swollen and can be pressed deeply without causing pain; but the skin is cold, the heart beats very frequently, no pulse can be felt at the wrist, the respirations are very frequent, and the secretion of urine is suppressed. The mind is affected little or much. The patient dies on the first or second day of illness. At the post-mortem examination acute peritonitis is found, but not necessarily perforation of the peritoneum or disease of any other abdominal structure.

FIBROID PHTHISIS.

In closing a paper on this topic in the *Lancet*, November 5th, Dr. Meredith remarks:

A summary of the various modes of origin of such conditions as ultimately assume the characters of non-tuberculous or simple fibroid phthisis may not be amiss here. Regarding chronic pneumonia as a generic term, and to represent the pre-phthisical stage of the disease, it may be held to embrace cases which originate more or less definitely and acutely, and likewise a group of cases which are more or less chronic from the first. Of the latter class the existence of a primary cirrhosis of the lung, resembling renal cirrhosis, is held by many authorities, and it is certainly the characteristic lesion of pneumoconiosis. More commonly, however, chronic bronchitis, with peri-bronchitis leading to localized lobular indurations and bronchiectasis, from the starting point of the disease. In other cases bronchiectasis appears early, and the stagnant secretions cause circumscribed inflammation round the dilatations, ending in induration. More or less pleurisy is frequently associated with these lesions which form the basis of the most classical type of fibroid phthisis. Of the other or acute class of cases, pleurisy and acute broncho-pneumonia are most frequent. Some doubt whether a simple pleurisy can originate an induration of the lung, but the evidence is in favor of such a sequence, for inflammatory changes in the lung are frequently traceable to progressive ingrowth from the pleura. In the last place, and least frequent, is acute pneumonia. Evidence has lately been accumulating in favor of its occasional, though very rare, issue in induration. Some confusion has arisen here because two different forms of induration have been observed to occur after this affection. In one of these the lung appears much shrunken, either in whole or in part, bronchiectatic and altogether resembling Corrigan's cirrhosis. Now in such cases it will invariably be found that the lesion is due to pleurisy which has complicated and outlived the pneumonia. The other or genuine pneumonic induration has individual features of its own totally different from those presented by any other chronic affection of the lungs, and hence I claim that it is justly entitled to a separate designation. Dr. Coupland, in this country, was the first to put on record the microscopical appearances in this affection, which consist in a fibroid transformation of the pneumonic exudation. Working further at this subject led me to suggest the name "fibroid pneumonia" for it. It shows but slight bronchiectasis, but may issue in fibroid phthisis through intercurrent inflammation or necrosis of the indurated tissue.

PRACTICAL HINTS REGARDING CHILDREN.

Always teach a nurse that a child cannot swallow as long as the spoon is between the teeth; that it is advisable to depress the tongue a brief moment, and withdraw the spoon at once, and that now and then a momentary compression of the nose is a good adjuvant.

Powders must be thoroughly moistened; unless they be so, the powder adhering to the fauces is apt to produce vomiting.

Inunctions require a clean surface, and are best made where the epidermis is thin, and the net of lymph-ducts very extensive, as on the inner aspect of the forearm and the thigh.

Febrifuges and cardiac tonics, such as quinine, antipyrine, digitalis, strophanthus, sparteine, convallaria, etc., are tolerated and demanded by infants and children in larger doses that the ages of the patients would appear to justify.

Mercurials affect the gums very much less in young than advanced age.—Dr. Jacobi, quoted in *Pacific Medical Journal.*

UTERINE CONTRACTION IN PREGNANCY.

In a recent number of the *Lancet* Dr. Windle reports the following case in illustration of the fact that these contractions are not, as is usually the case, always painless; indeed, in some instances that have come under his notice the contractions have been such as would lead one to infer that premature labor was about to take place. He says: The first case of this kind I have noticed occurred about three years ago, when I was consulted by a woman in the seventh month of pregnancy for what she described as "cramp in the stomach" and from which she had suffered more or less for some time. Suspecting premature labor was about to occur I visited her at her home, when on palpating the abdomen I found the uterus contracted, and from this I concluded that labor had commenced. The pains continued for about two months, more or less modified by treatment up to the time of actual labor at full term. I may mention that my patient was in good health, and that her previous pregnancies had been normal. Remembering the fact of the occurrence of painless intermitting contractions, I concluded that the case was a modified form of the normal state of things—viz., painful instead of painless contractions. Before the termination of pregnancy I had many opportunities of verifying the opinion I had formed. In this and subsequent cases, so far as I could make out, the contractions had no effect on the os or cervix, but the membranes became somewhat, but not markedly, tense. Since then I have noticed many similar cases, but in only one where the painful character of the contractions continued for any considerable period. In this case, also a multipara, they occurred regularly from January 27th, 1892, to February 15th, during which time I visited her every day. Delivery took place on March 2nd. It is a very common experience to meet with cases of threatened abortion and early miscarriages where pains constitute the only symptom, but which subside after a time without anything being expelled from the uterus, and for labor to take place at the full term of utero-gestation. I believe that many of these cases are examples of the painful instead of the normal painless intermitting contractions of pregnancy. If such be the case we have an explanation of the fact that it is rare for abortion or miscarriage to occur when pain is the only symptom.

ON UNDERCLOTHING.

In the *Memphis Medical Monthly,* December, Dr. Randle gives some interesting suggestions upon this important subject. He says: It is better not to have our underwear fit too closely. The ankles much oftener itch than other parts when exposed to the air, because the socks worn closely-fitting confine all the perspiration under them to the skin. Knit underwear usually fits the skin closely, and therefore cannot be recommended for health. One using it should bathe at least twice as often as if wearing more loosely-fitting goods. Tightly-fitting under-

wear often produces an itching, especially when first taken off; hence, you will often see people scratching their body on first going to bed at night.

The knit shirt is much worse for a man of sedentary habits than for one of active life, for the motions of the latter force some circulation of air under the shirt.

If a man will wear a flannel shirt next to his skin a week, he will find at the end of the time, that the shirt will be but little soiled, and that his skin will be greatly in need of bathing. If he will wear a cotton shirt the next week, he will find, at the end of the time, that the shirt will be soiled, but his skin will be clean. Perspiration adheres much better to the skin than to any woolen goods, but much better to linen or cotton goods than to the skin. When you bathe, try a cotton and flannel towel, and see which best dries the body. A woolen towel is almost worthless for wiping the body; so is a woolen undershirt almost worthless for cleansing the body.

Good canton flannel, made loosely-fitting, is healthful and comfortable underwear, and causes no itching, while tight-fitting woolen goods are neither healthful nor comfortable, are apt to produce itching, and cause the skin to need washing about four times oftener than the former goods does. The better the skin is kept ventilated, the cleaner it keeps, the less susceptible it is to contagious and other foreign influences, and the more effectually it relieves the system of impurities and waste material. Then, wear loosely-fitting cotton underwear.

SELF-EXAMINATION AND INDEPENDENT THOUGHT.

Finally, gentlemen, let me exhort you to cultivate the habit of examining yourselves. At the conclusion of each hospital visit consider what you have seen and learnt and thus impress the lessons on your memory. Hurry not from one thing to another. In this, as in so many other things, the more haste the less speed. At the same time do not dawdle. Be intent, but be deliberate. By questioning yourselves you will be your own best teachers. Rely not so much on others as on yourselves. By culivating self-reliance in the study you will best promote self-reliance in your future vocation. We hear much at the present time of German universities, of German teachers and German students. We acknowledge their superiority in some respects, more especially in the opportunities for, and the devotion to, research, and we would, if our restrictive laws did not hinder, imitate them in this; but we wish you to hold by the freedom and independence of thought and the energy and activity of Englishmen. We would not that you should be dragged at the chariot-wheels of any heroes, for that implies deadness or weakness, but rather that you should stand erect and march on by your own force with the firm, straight, dignified step that indicates strength of mind, determination of purpose and unselfish nobility of character.—From address of Dr. Humphrey, of Cambridge University, England, *Lancet*.

OVARIOTOMY IN OLD WOMEN.

At a recent meeting of the Southern Surgical and Gynæcological Association, Dr. Joseph Taber Johnson (*Memphis Medical Monthly*), read a paper upon this subject in which he reported three cases. He felt quite sure that prolonged anæsthesia and manipulation within the peritoneal cavity would have proved fatal. The first patient was 67 years of age, and the tumor weighed fifty-two pounds. The second case was one of multilocular ovarian tumor. The patient was 68 years of age, and the tumor removed weighed sixty-four pounds. On October 10th of this year, he removed an ovarian tumor weighing fifty-six pounds from a lady 67 years of age, but who looked to be 100. Improved methods,

quicker operations, antiseptic technique and provisions against shock, show thirty-three recent cases between the ages of 67 and 82 with only two deaths, against twenty-four cases done twenty years ago, between the ages of 60 and 67, with a record of six deaths. These figures demonstrate in addition to improved technique the surprising fact that old age is no contraindication against ovariotomy.

THE NATURE OF IMMUNITY.

The facts here referred to, and others, show that "immunity" is not attributable to the acquisition of any special means of protection, or defence, against the particular infecting microbe, to which the individual is "immune;" nor to the acquisition of any increased capacity of defensive action against the same; but to the acquisition of a high degree of sensitiveness of the living tissue elements to the presence of those microbes and their toxins—to the acquisition of a special development (by exercise of a special kind) of a defensive faculty of perception, with which the living elements of certain tissues, in all individuals exposed to microbic infection, are of necessity endowed—a *perceptive faculty* of the tissues, bringing into play various defensive vital actions which may be subjects of pathological or chemical research, but as to the ultimate nature of which we can get no further than the recognition of the fact of its existence, expressed in the words of a classic authority: "Natura illud, a quo damnum aliquid acceperit semper abhorret.—Dr. Kanthack, *British Medical Journal*, November 5.

THE CAUSATION OF SEA-SICKNESS AND ITS SYMPTOMS.

Dr. W. Downing (Birmingham) writes: The causation of sea-sickness has long been understood to be connected with disturbance of the nervous system, bromides being given on that account. There is no doubt that the mere mechanical vomiting is produced in this way, the central nervous centre in the medulla being in a state of irritation. The accompanying symptoms, however, of severe headache, coldness of surface, and faintness are probably not the immediate result of nervous derangement. It is probable that, owing to the various oscillatory movements (which produce the temporary disorganization of the nervous system, and the consequent disturbance of the vagi and hepatic plexus) the bile is not restrained from directly entering the duodenum in large amount, and as a consequence becomes absorbed by the blood, as shown by the varying color of the face. Bile circulating in the blood in great excess acts in a poisonous manner, and produces the symptoms alluded to. Hence, relief may be anticipated by the free use of cholagogue remedies for a day or two before commencing a voyage. If bile is scarce, vomiting of food in the stomach may occur, but the headache, faintness and general prostration will be absent.

Recommendations of Therapeutic Agents.

Antipyrine as an Analgesic.—Dr. J. J. B. finds that neuralgia, especially facial, is in the majority of cases controlled and dispelled by antipyrine; it is his practice to divide 30 to 35 grains into powders of 5 grains each, and administer one every 20 or 30 minutes until the pain has ceased or the powders are exhausted. In cases of unusual severity he commences with 15 grains, after which the patient takes 5 grains every 20 or 30 minutes. He gives antipyrine in these cases with the same confidence of success as when giving morphine, and with the assurance that there will be no antipyrine habit developed as is the case

with opium and its alkaloids. He has also used ½ grain—5 doses hypodermically in cases of intercostal neuralgia; the pain subsided almost immediately, the antipyrine doing its work much quicker than morphine.

Medical Items.

"Wanted, a gentleman to undertake the sale of a patent medicine; the advertiser guarantees it will be profitable to the undertaker."—*Ex.*

The first operation of symphysiotomy in the United Kingdom was done on November 22nd, at the Rotunda Hospital in Dublin, by the Master, Dr. W. J. Smyly. Both the mother and child survived.

It has been decided to hold the third annual meeting of the American Electro-Therapeutic Association in Chicago on September 12, 13 and 14, 1893. The transactions for 1892 are published in this JOURNAL.

The Kentucky School of Medicine, Louisville, announces that after 1893 three courses will be required of all graduates of their school. We are pleased to note all such advances in higher standards in medical schools.

The Faculty of the Harvard Medical School at their last meeting voted, by a majority of twelve to nine, not to ask the corporation of the University for authority to admit women to graduate courses if at any time or in particular cases it should wish to do so.

Mayer, as a result of the study of forty schools in Bavaria with over 2,000 pupils, finds that with upright writing 55 per cent. of the children sat in a good position, whereas with sloping writing only five per cent. were found to do so. He finds that the better the position of the pupil the less the letters incline, and that if vertical writing is taught, children sit in a good position with far less trouble.—*Boston Med. and Surg. Jour.*

Dr. Naegeli orders the patient troubled with too much wax in the ear, accompanied with pain, to yawn often and deeply. The pain will soon disappear. He also, in cases of nasal catarrh, inflammation of the palate, sore throat, and earache, orders the patient as often as possible during each day to yawn from six to ten times successively, and immediately afterward to swallow. The result will be surprising. If one looks upon yawning as a natural massage for certain organs, he will reach a satisfactory explanation of its curative properties.—*Ex.*

Professor Wilson says that in cases of gouty rheumatism, the anti-rheumatics yield poor results. Blistering will not be of any value for permanent relief, but may give temporary relief. He advises the administration of cod-liver oil in the earlier stages, but not in the later. In the later stages he prescribes some arsenical preparation, preferably Donovan's solution, beginning with five drops three times a day, increasing one drop every other day until the physiological effects of the drug are experienced.

The following sums of money have been placed at the disposal of the American Microscopical Society, to be given as prizes for the encouragement of microscopical research, and Professors Gage, Kellicott and Seaman were appointed

a committee to prepare the conditions on which they should be granted. The competition will be open to members of the society and to those who make application for membership before submitting their papers to the committee. Two prizes of fifty dollars. Two prizes of twenty-five dollars. Two prizes of thirty dollars. Two prizes of fifteen dollars.

The "American Text-Book of Surgery," edited by Professors Keen and White, of Philadelphia, which has only been issued a few months, is already a phenomenal success. It has been adopted as a text-book by forty-nine of our leading medical colleges and universities. Nearly five thousand copies have been placed in physicians' libraries, and every indication points to a sale of at least as many copies more in the next six months. Dr. Nicholson, of Chicago, is now preparing a "Syllabus of Lectures on the Practice of Surgery," arranged in conformity with the "American Text-Book of Surgery," which will be a valuable aid to all who have this great book.

Hepatic disease as a cause of madness has been studied by M. Charrin. He has reported three cases of madness more or less strongly marked in which hepatic disease was present. The urine of these patients was poisonous (toxique.) An hepatic form of madness may exist, as there is a similar disease from Bright's. In these patients the mental trouble improved in proportion to the improvement in the disease of the liver; these are conditions worthy of special note. Patients with mental disturbance accompanied with visceral lesions should be treated with the greatest care. Gastric obstructions sometimes play an important part in causing many forms of mental aberrations, and by treating these lesions the madness in some cases is greatly relieved or even cured.—*Sanitarian.*

The young men and young women who aspire to obtain academic or college educations, and whose parents cannot well afford them that expense, will be interested in the work of the *Cosmopolitan Magazine,* which has offered for the year 1893 one thousand scholarships at any of the leading colleges or schools of the United States, upon the condition of introducing the magazine into certain neighborhoods. Yale, Vassar, Harvard, Ann Arbor, Chicago, the Southern colleges, the great schools of art and medicine, all are alike open to the ambitious boy or girl who is not afraid of a little earnest work. The *Cosmopolitan* sends out from its New York office a handsomely printed pamphlet to any applicant, telling just what is necessary in order to secure one of these scholarships.

Dr. Horatio C. Wood remarks: The local effect of quinine upon mucous membranes is distinctly irritant, and I have met with many people in whom the cinchona alkaloids produced marked gastro-intestinal irritation; so that chronic diarrhœa or gastro-intestinal catarrh have come, in my mind, to be very important contraindications to the use of the drug. The irritating effect of quinine is also often manifested at its point of exit from the body, and the existence of cystitis or conditions allied to it should make the practitioner very careful in the administration of the drug. Some time since I called to see a personal friend, a very eminent surgeon, who was convalescent from an inflammation of the neck of the bladder, but who was much prostrated every afternoon by a violent attack of pain entirely out of proportion to the amount of local disease apparently remaining. Finding that the patient was taking quinine freely as a tonic, and that the time of attack of pain was coincident with that at which quinine was being most freely eliminated from his body, I suggested the disuse of the alkaloid, the result being the immediate disappearance of pain.—*Ex.*

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HYSTEROMYOMECTOMY FOR LARGE MYOMATA OF THE UTERUS.*

BY HUNTER ROBB, M. D.,
Associate in Gynæcology to the Johns Hopkins Hospital, Baltimore.

The intra-peritoneal method of treating the pedicle after the removal of a myoma of the uterus is probably not generally employed by the majority of operators. The dangers of sepsis and hæmorrhage, which, it is believed, are to a great extent obviated by treating the pedicle according to the extra-peritoneal method, have always been thought sufficiently great to condemn any innovation. It is, however, not difficult, I think, to appreciate that sepsis is very apt to follow when the pedicle is treated according to the external method by transfixion, because this is of necessity followed by strangulation of tissue; and it is a well-known fact that constricted tissues are more susceptible to bacterial invasion than those not thus compressed. Again, a pedicle thus treated, besides being exposed constantly to the bacteria which are always present in the skin (the staphylococcus epidermidis albus) is liable to become infected on account of the necessity of dressing the wound frequently in order to tighten the clamp. Now if this mass of tissue once becomes infected, the peritoneal cavity, being in such close proximity, would very likely be involved. It has been claimed that

*Read before the Clinical Society of Maryland, December 2nd, 1892.

where for any reason the virulent micro-organisms can not be kept out of the field of operation, the extra-peritoneal method of treating the pedicle promises more favorable results. But granting that its adoption may protect the peritoneum from infection with these micro-organisms, the method in other ways affords fresh chances for infection. I have previously shown that the drainage-tube is subject to similar criticism. If our technique is perfect the result should be successful in every case, and the adoption of this method in cases of hysteromyomectomy should offer but little more danger (with the exception of that due to the greater length of time consumed in performing the operation) than in an ordinary ovariotomy. In many instances the pedicle that is made after the removal of an ovarian cystoma is as large as that which is left after the removal of the uterus for a myoma. In those cases where the Fallopian tubes and ovaries have undergone inflammatory changes and become firmly adherent, the bleeding that follows their removal is often profuse, requiring for its control the application of many ligatures. Many ligatures, too, may be necessary in cases where a myoma of the uterus is to be removed, and during the operation the cavity of the uterus is opened.

In the cases just described, which are not infrequently met with by gynæcologists, we do not hesitate to close the abdominal wound. Why, then, should we treat the pedicle formed after amputation of the uterus in a different manner, and why should not the dropping of it into the abdominal cavity, with closure of the wound, be just as safe as in an ordinary ovariotomy, or after the removal of an extra-uterine sac, or after performing a myomectomy? Of course it will be objected at once, that in a hysteromyomectomy, a communication is opened up between the peritoneal cavity and the cervical canal—a canal, which, under pathological conditions, contains, in a certain percentage of cases, pyogenic micro-organisms. We admit the force of the objection, but will, in a few moments, show how any danger from this source may almost surely be obviated. We believe that it will not be long before the external method of treating the pedicle after removal of myomata of the uterus will be abandoned altogether for the more rational and scientific proceeding of dropping it into the abdominal cavity. We might also mention another method which was formerly employed by a number of operators, viz., that of fixing the pedicle in the lower angle of the incision without transfixion. The first to devise and put into practice this method in this country was Dr. H. A. Kelly, and the advantages supposed to be gained by treating the pedicle in this manner were the lessening of the dangers of sepsis, and also the prevention of hæmorrhage. As a matter of experience we were never brought face to face with this emergency, and this fact has certainly shown us that the danger of hæmorrhage is not so great as we had feared; while, on the other hand, we now feel confident that the dangers of septic infection cannot be said to be obviated by it, and that by the exposure of the pedicle, the chances of infection are even greater than when it is dropped inside. I have had charge of a number of cases where the pedicle was treated according to this second method.

Later on, I began to practise the dropping of the pedicle into the abdominal cavity, and have to my mind demonstrated that the danger of hæmorrhage and of infection is not, with proper precautions, much greater than in any other operation involving an abdominal section. I will not here attempt to describe the technique that should be carried out, but will mention only what we consider to be of the greatest importance in maintaining an aseptic field at the operation. The uterine cavity and the vagina should be sterilized as thoroughly as possible; the former can be rendered aseptic by curetting both the uterine and cervical mucosa several days prior to the removal of the myomatous tumor, and at the same time we cauterize gently the cavity of the uterus with the small point of a Paquelin cautery, and immediately afterwards pack into the uterine cavity a strip of ten per cent. iodoform gauze, which is removed the day before the operation. The vagina should be made sterile by irrigating it twice daily for two or three days prior to the operation with a warm aqueous solution of carbolic acid (1-3 per cent.). Of this solution at least a litre should be used each time, and in the intervals between the douches the vagina should be packed with strips of ten per cent. iodoform gauze. Tho external genitals should also be well washed twice daily with a warm two or three per cent. aqueous solution of carbolic acid, and a good sized pad of sterilized gauze or cotton afterwards applied over the vulva. In the treatment of the pedicle after the removal of the tumor mass, the cervical canal should be sought for on the cut surface, and again perfectly sterilized by plunging the Paquelin cautery well into the lumen of the canal. If these details be carried out it seems to me that the cut surface of the uterine tissues may with safety be immediately approximated with a prospect of good union resulting, providing always that we use sterile ligatures and maintain our septic technique throughout. The objection that there is danger of hæmorrhage after the internal method of treating the pedicle should not be sufficiently strong to condemn it. There are perhaps a few cases in which we may not be able to control the bleeding vessels, but in most of the instances in which hæmorrhage occurs, it is due to faulty technique on the part of the surgeon. We have several simple expedients at our command which will reduce this danger from hæmorrhage to a minimum. After ligating the broad ligament on the side near the pelvic wall, and then using the hæmostatic forceps on the side near the uterus, we can divide the broad ligament between these two points; next, we transfix the cervix with a needle and carry through at this point a double sterile chromicized catgut ligature, tying on both sides. After this the tissues may be cut without the loss of more than a few drops of blood. If we prefer to do so, we may tie the broad ligament on either side with a double row of ligatures and cut through between them. Instead of transfixing the cervix we may encircle the tumor at or just above the cervix with a provisional rubber ligature, thus temporarily preventing any bleeding from taking place, and then after removing the tumor pass the sutures through the tissues of the pedicle, and approximate the surfaces. The provisional rubber ligatures may then be removed, and any additional sutures that may be required passed to control any bleeding that may continue. Another

method that may be followed in cases where the uterine arteries are not displaced is to ligate them on both sides of the uterus, after transfixing and cutting into the broad ligament; we can then either apply the provisional rubber ligatures in the manner mentioned above and remove the tumor; or immediately remove the tumor without the application of the rubber ligature, and treat the pedicle as just described. Or again, we can first ligate the blood-vessels of the broad ligament separately and cut through the ligament before applying the provisional rubber ligature.

The unfavorable results that follow the dropping of the pedicle have in the great majority of cases been due to infection, but with our continually improving technique consequent on a better appreciation of the importance of observing bacteriological precautions, the mortality will undoubtedly be much lowered. The results that we have obtained by following this method within the past year and a half have been thoroughly satisfactory, and are better than where the other methods were employed. If then as good or better success may be obtained by this way of treating the pedicle, we believe that it should be more generally adopted, especially since the period of convalescence is much shortened and there is not nearly so much danger of the hernial complications that are apt to follow other methods.

In conclusion, I would say, that we now drop the pedicle in every case of hysteromyomectomy and are in the habit of treating it in this respect just as we would the ordinary pedicle in an ovariotomy.

ASPERGILLUS OF THE EAR.

BY JAMES L. MINOR, M. D., OF MEMPHIS, TENN.

Of the various forms of parasitic disease of the outer ear, the most frequently observed is that caused by a fungous growth—the aspergillus, or common mould. Judging from hospital reports, something less than one in a thousand ear patients will be found to suffer from it. My own experience has been to find a much larger proportion, and diligent search will demonstrate the same in the hands of others, I suspect.

The aspergillus does not attack a healthy ear. The soil must be prepared for it—as from putting oily substances which favor the development of mould, into the ear, the habitual use of the ear-pick, which is apt to cause an obstinate form of otitis, and thus offer an inviting field for the deposit and growth of the fungus; and other inflammatory conditions of the external auditory canal may act in like manner.

Unhealthy, damp surroundings are thought to favor the development of mould in the ear. In suppurative imflammation of the middle ear, the aspergillus is rarely found. The habitat of the aspergillus once established, it produces a very obstinate, firm inflammation. The fungous growth extends into the tissue of the skin, develops with wonderful rapidity, is exceedingly difficult to remove, and very prone to return.

Symptoms of aspergillus in the ear will vary with the severity of the inflammation produced. There may be simply itching, slight pain, and a sense of fulness of the canal, with more or less tinnitus and impaired hearing; or there may be an exaggeration of all of these conditions. There is usually a scanty serous discharge, which may contain flaky matter, or occasionally lumps, resembling softened, but very tenacious wax.

Examination with the otoscope usually shows the canal to be filled with material resembling hardened wax, or like wet paper. Syringing the ear usually removes this material readily, but not completely; for it will be found that spots here and there on the surface of the canal remain after prolonged syringing, seeming to be part and parcel of the skin, and can only be removed by instrumental aid.

Microscopic examination of the material removed from the ear is necessary to establish a positive diagnosis. A small bit, placed upon a slide, teased out, and examined with a 100 diameter magnifying power, will show the characteristic growth of aspergillus—a matrix of delicate fibers, and numerous small, round objects about the size of blood corpuscles, with here and there a fiber capped with a head resembling a sycamore ball.

There are two varieties of aspergillus—the aspergillus nigricans, and the aspergillus flavescens, differing from one another in both color and shape, as is shown in the accompanying cuts. Either of these varieties may at times be of greenish color, and then is classed by some as a separate variety—the aspergillus glaucus.

The treatment of aspergillus consists in the thorough removal of the growth by syringing with hot water, and instruments when necessary, and the boracic acid tampon; the treatment to be repeated daily, until the growth, its attendant inflammation and discharge disappear. Ordinarily, a week will suffice. I have found this treatment far superior to any other.

Brief histories of the two cases from which specimens were obtained for the accompanying cuts, are as follows:

Case I.—*Aspergillus Nigricans.* Mr. S., æt. 38, consulted me December 9th, 1891, for trouble with his ears. Six or eight years ago he formed the habit of using an ear-pick to remove wax from, and relieve itching of, the ears. One year ago a sense of fulness of, and pain in the ears, with tinnitus and some impairment of hearing, were experienced. It was noticed, too, that the ear-wax was much increased, and that relief was usually afforded for a time by free syringing and removal of large masses of waxy material from the ears. This state of affairs has existed up to the present time. I found the hearing impaired. A watch which is normally heard at sixty inches had to be placed in contact with the ear to be heard. Examination showed the auditory canal to be blocked by a mass which resembled ear-wax. This was partially removed by syringing, that remaining requiring the use of angular forceps. The canal was red and sensitive, but the hearing was much improved, the watch being heard at thirty inches.

The canal was dried out with absorbent cotton, and a boric acid tampon was introduced.

The mass which had been removed presented the appearance of wads of wet brown paper, and on examination with the microscope proved to be *aspergillus nigricans*. (See figure 1.)

The patient returned the next day, when the treatment was repeated. This was done daily for one week, when a cure was effected.

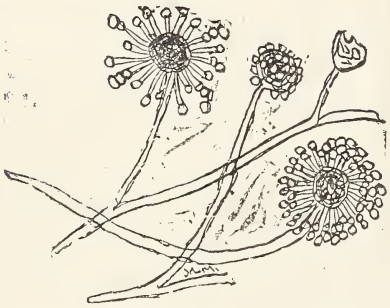

Fig. 1.

Fig. 2.

CASE II.—*Aspergillus Flavescens.* Mr. B., æt. 45, consulted me February 4th, 1892. He always had an abundance of wax—and to remove it used an ear-pick. For four or five years past has occasionally dropped sweet-oil into the ear with a view of checking the secretion of wax.

Six months ago the ears began to itch intolerably, and after a few weeks became painful. Later, the hearing was impaired, and noises sounded continuously in the ears.

I found hearing reduced to contact for the watch—and examination showed the canals to be filled with wax. Syringing removed the major portion of wax, but much of it clung with such tenacity to the walls of the canals that it was necessary to resort to the curette and angular forceps to get it entirely away.

The canals were left red and irritable. Boracic acid powder was put into the ear, and he was directed to return daily for the same treatment. Ten days' treatment effected a cure.

Microscopic examination of the material removed from the ears showed it to be composed of *aspergillus flavescens.* (See figure 2.)

Society Reports.

TRANSACTIONS OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

SECOND ANNUAL MEETING, HELD IN NEW YORK, OCTOBER 4, 5 AND 6, 1892.

SECOND DAY, OCTOBER 5, MORNING SESSION.

Dr. W. J. Herdman, of Ann Arbor, Michigan, read a paper on THE NEED OF GREATER SIMPLICITY AND UNIFORMITY IN ELECTRO-THERAPEUTIC APPARATUS.

The object of this paper was to enlarge the scope of the subject placed under

the consideration of the committee at the last annual meeting. The appliances now considered to be essential are not a few, and hence the need for as much simplicity as is consistent with accuracy and facility of manipulation. Nine-tenths of all medical graduates have little or no knowledge of the laws governing the action of electricity, either within or without the body. If this Association would do all in its power to fix a proper standard for those desiring to practise in this branch of medicine, the colleges would soon find it to their advantage to make a knowledge of this subject a part of their curriculum, or possibly one of the entrance requirements. There is much need for more uniformity in the construction of instruments, and particularly as regards the shape, size and material of electrodes. There is also no good reason why instruments should not be made so that repairs can be made by the physician himself, and so avoid the present expensive and vexatious delays. He was in favor of appointing, at this meeting, committees to report on standards for static machines, constant current generators, and on electrodes. He did not claim that even with standard instruments uniform results would be obtained by different observers; for the personal equation must be taken into consideration. He did claim, however, that we should endeavor as soon as possible to determine the value of this personal equation.

DISCUSSION.

Dr. Hutchinson said that the author's remarks on the importance of greater simplicity of construction, and facility in repairing, harmonized exactly with what he had been urging for many years past; he had fought with all his might against hidden and inaccessible parts of machines, and particularly against closed cells.

Dr. Goelet was glad to see that others had recognized the difficulties which he had had to contend with in the application of electro-therapeutics and to which he had called attention. The lack of uniformity in the construction of electro-therapeutic apparatus was felt most keenly, perhaps, in consultation practice, where it was often sufficient to put to naught the advice given by the consultant.

The tendency to economize in the construction of such apparatus is a great mistake, and although he had himself been guilty of recommending the use of the cheaper metals in the construction of electrodes for the positive pole, he had seen his mistake, and could now most positively say that nothing so far devised could equal platinum for this purpose, unless the claims for a new alloy of lead described in the *Pacific Record* of September 15th, of this year, proved, after practical tests, to be well founded. The composition of this alloy was given.

Dr. Waite said that one of the chief obstacles presented to the manufacturer was a lack of knowledge on the part of the purchaser as to just what he wanted. The voltage of the instruments in the market is well-known; the trouble is with the electrodes. The variations in the different faradic coils were due to many factors, and he saw no way of securing uniformity of construction, except by extended experiments with many different machines.

Dr. Nunn said if the manufacturers could only be induced to make the connections interchangeable, it would be a great step in advance. There seemed to be no good reason why this Association should not adopt a standard for plugs and screws. In determining the standard for coils, much latitude should be given, the requirements for a standard coil being determined from a therapeutic standpoint.

Dr. J. H. Kellogg, of Battle Creek, Michigan, thought the only way to obtain

an exact knowledge of what is wanted in a medical induction coil is to make a careful and elaborate study of the tracings taken from the currents of many different kinds of coils. He was at present engaged in such a study, and it promised to be very fruitful of results.

Dr. Herdman, in closing, said that he had been gratified at the unanimity of opinion evinced during the discussion. It had been truly said that we did not know what we wanted, but we shall never get anywhere unless we start. We are ourselves responsible for what the manufacturers are doing, and as a national organization we should take this matter in hand, and if committees are appointed to do this work, they should not forget the physiological experiments alluded to by Dr. Kellogg, for such a study is absolutely essential to accuracy and completeness of the work.

A CONTRIBUTION TO THE ELECTRICAL TREATMENT OF CYSTIC GOITRE AND HYDROCELE; ALSO A NOTE ON PSORIASIS, by Dr. Charles R. Dickinson, of Toronto.

The author reported two cases, one of goitre, and one of hydrocele, which he had treated by electricity. The first one was a multilocular cystic goitre, occurring in a young man. The positive electrode was placed between the shoulders, two insulated needles made of piano wire were connected with the negative pole, and one inserted in the isthmus and the other in the left lobe. A current of thirty milliamperes was used for a few minutes, and then a small electrode was placed over the tumor instead of at the back, and a current of twenty milliamperes employed for five minutes more. After the application a simple dressing was applied. The treatment produced little change; so, thinking that greater benefit would ensue if the fluid in the cyst were a better conductor, the contents of the cyst were withdrawn with an aspirator, and the cyst then distended with an aqueous solution of chloride of sodium, one drachm to the ounce. After the electrical treatment with this solution it was withdrawn, along with much gas. The cyst refilled, but much more slowly than it had done after simple tappings. The treatment was repeated, and then a compress applied so as to make firm pressure. After this, improvement was steady, and four or five months later the lump had disappeared, and he was in much better health. He firmly believed that a permanent cure had been obtained, until on writing to the patient quite recently, he learned that last June there had been some return of the swelling in the neck, and that at present the patient was trying some quack remedy. The lesson which he learned from this case was that the cyst wall should have been thoroughly obliterated, and the treatment persisted in for a longer time. In the case of the hydrocele the patient had been tapped three times, the cyst refilling each time within three or four weeks; and he had once had carbolic acid and glycerine injected at two different times. Seven ounces of straw-colored fluid were then withdrawn, and the sac filled with a warm salt solution, twenty grains to the ounce, and the needles used much as in the other case. A current of fifty milliamperes was used for fifteen minutes, and then a current of twenty-five milliamperes for five minutes more. The sac was then emptied, and it was noted that the quantity of fluid had been considerably decreased, and that there was much gas present. A borated dressing was applied. On the following day the testicle was strapped in order to close the walls of the sac. This same patient also had some spots of psoriasis on the forearm, scalp and shin, which had not yielded to treatment, notwithstanding the patient had consulted a number of eminent men. There was no specific history. To lessen the resistance to the

passage of the current through these dry scales they were moistened with salt and water, and each spot treated for five minutes with a current of from ten to thirty milliamperes, and after repeating this treatment daily for five days, the spots were decidedly improved. He was then directed to make use of a very mild chrysophanic acid ointment, twenty grains to two ounces of lard. Three months later there was no sign of the hydrocele, his health was much improved, and he stated that the psoriasis had entirely disappeared three weeks after stopping the electrical treatment. When the injections of carbolic acid had been made for the relief of the hydrocele, he had been compelled to quit work for several weeks, whereas after the electrical treatment he was able to resume work in a considerably shorter time. Regarding the strength of the current, the author said that his endeavor was to use the mildest current which would prove curative, as many delicate structures were included between the poles. When introducing the needles into the goitre the patient should be directed to swallow; then if the needle pierced the posterior wall, the external end of the needle should be raised during the act of swallowing. The strength of the current should be very gradually increased, and the interval between the operations should be at least one week.

DISCUSSION.

Dr. Herdman said that in considering any form of treatment for goitre, one must bear in mind the great differences existing in the various stages of the disease. There are ordinarily three stages of enlargement, viz.: (1) where there is a simple dilatation of the vascular structures; (2) a stage in which there is the formation of cysts; and (3) a fibrous condition, due to an increase in the connective tissue substroma. The cystic form is identical with the condition existing in hydrocele, and, as in the latter condition, injections of such irritants as carbolic acid, or iodine, yield better results than electrolysis. But the fibrous form is exceedingly refractory to internal treatment, and to most other methods, except the electrical treatment. The electrical treatment is quite tedious, but it is possible by electrolytic action, to secure absorption, and at any rate, better results are obtained than by any other method.

Dr. Kellogg agreed with the last speaker as to the limitations of electrolysis in the treatment of goitre, but it must be remembered that some patients will choose the electrical treatment rather than a cutting operation, even though the latter is much more likely to prove successful. He had been pleased with the method of injecting the cyst with a saturated solution of iodine of potassium, and then submitting it to electrolysis. The resulting decomposition with evolution of nascent iodine had a salutary effect on the lining membrane of the cyst.

Dr. Herdman remarked that he had also had satisfactory results with this method; but he had not been able to satisfy himself about the occurrence of this decomposition.

Dr. Kellogg replied that he knew that such a decomposition occurred, for in using the solution on the electrode in the treatment of fibroid tumors of the uterus, on withdrawing the electrode it was found deeply stained with iodine if the positive pole was employed.

The President said that the frequent reports of successes in the treatment of goitre by electricity had led him to try this method, but the results obtained gave him reason for thinking that many confounded the symptomatic recovery with an organic change in goitre. The great obsticle to success was our imperfect knowledge of the pathology of the condition. As the goitre is associated

with exophthalmos and rapid action of the heart, we have long looked to the sympathetic system for the cause. Erb has pointed out that the condition in these cases is often one of neurasthenia, and more recently we have been told that the changes observed are due to changes in the restiform bodies. He was now trying to follow out this idea by applying the negative pole to the base of the brain, and the positive pole to the forehead, and hoped in this way to secure an effect upon the restiform bodies. Most of his cases had been treated by electro-puncture, preceded by electro-cocaine anæsthesia, using an insulated platinum needle, and the indifferent electrode on the back of the neck. He had also tried long static sparks. He had noted, as a rule, that the treatment was followed after one or two months by a diminution in the swelling of the neck, and in the exophthalmos, with a reduction in the rapidity of the heart's action, but he had seen no *remarkable* diminution in the size of the goitre. To Gautier was due the credit of introducing the electro-chemical method, already referred to by the other speakers. This method Gautier now termed interstitial electrolysis.

Dr. Goelet said that Gautier's results, particularly in the treatment of endometritis, and in diseased conditions of the female urethra, had been very satisfactory. He used a solution of iodide of potassium (1 to 10) upon a cotton-wrapped platinum applicator with a current of from fifty to eighty M., for five to ten minutes.

Dr. Walker said that he could recall numerous cases in which he had found electrolysis a most successful method of treating fibroid goitres. The cystic forms, like œdematous fibroids, did not come within the range of electrical treatment. He first molded a tin electrode to the shape of the enlargement of the neck, filled it in with clay, and covered it with two thicknesses of cheese-cloth. The indifferent electrode was a large pad covered with absorbent cotton, and was placed between the shoulders. An assistant kept it constantly wet with a solution of bicarbonate of soda.

Not the slightest discomfort was experienced from using a current of 100 to 120 milliamperes for ten or twelve minutes at a time, repeated three times a week. In the case of two adults, the goitre had existed since childhood.

Dr. Herdman said he would be doubtful of a given tumor being fibrous, if it were of comparatively recent formation, for fibrous changes develop slowly. The President had spoken of exophthalmic goitre, which is a very different condition from cystic goitre. He had never failed to cure a case of exophthalmic goitre, yet he had treated some very severe cases. He believed exophthalmic goitre to be due to an irritation of the nerve centres controlling the circulation at the heart, and as a result of this irritation, contraction of Muller's muscle at the back of the eyeball is produced, giving rise to the exophthalmos. In accordance with the view of its pathology, he employed "the reversed continuous current" with the positive pole over the tumor and the negative one over the cervical enlargement of the spinal cord. He had tried all forms of the induced and continuous currents, but had had better and quicker results from the method described.

The President said that he had also found the electrical treatment of exophthalmos uniformly successful, but had never seen any reduction in the size of the fibroid enlargement, although the associated exophthalmos and the anæmia would be relieved.

Dr. Dickson, in closing, said that those cases which were probably the least amenable to treatment, occurred in girls of from fourteen to sixteen years of age,

and these should on no account be punctured; galvanism of the sympathetic was more appropriate. His object in filling the cyst with a saline solution was not so much to produce any special decomposition as to make use of an electrode which would fill the whole cavity, and so bring all parts under the local action of the current.

MEDICAL ELECTRICITY FROM AN ELECTRICIAN'S STANDPOINT, by John Carty, Esq., Vice-president of the New York Electrical Society

The author said that physicians in speaking of the medical uses of electricity employ terms which puzzle the electricians. He had asked in turn ten men holding the degree of "electrical engineer" what was meant by the terms Franklinism and galvanism, and not one of them could correctly answer the question, although all of them were familiar with the works of Faraday, Franklin and Galvani. The use of these terms had led many to believe that there are three different kinds of electricity, which is not true; the differences between the three "isms" is only one of degree. These relics of a former age should be cast aside. The so-called faradic current is an alternating current, the galvanic current is a "constant" current as regards the voltage and amperes, while the Franklinic current is a question of ohms and amperes and interruptions. When an alternating current is passed through an iron wire, the resistance of the wire increases rapidly, owing to self-induction, but with a copper wire the resistance remains the same. If a condenser be placed in the circuit of a 1000 volt direct current, it will prevent the passage of the current, but if placed in the circuit of an alternating current, it will allow the current to pass through; hence the alternating current acts in a paradoxical manner. The resistance of any inorganic body, speaking broadly, is different with every degree and form of the current. The human body in some portions may possess high self-induction, and in others act like a condenser. The author then dwelt upon the electro-magnetic theory of light, and the intimate relation of light to electricity, and, in concluding the paper, referred to Tesla's recent and very remarkable researches.

DISCUSSION.

In answer to various questions regarding the nature of an alternating current, the polarity of a medical induction apparatus, and the possibility of obtaining more exact knowledge concerning the nature at any given time of the currents employed in medicine, Mr. Carty said that an alternating current changes its polarity, but not necessarily any particular number of times in a second. There is an interruption in the current from an ordinary induction apparatus, but this does not necessarily coincide with the interruption in the vibrator. By calling to our aid the graphic method one could obtain tracings which would indicate the exact character of any current at the time the tracing was taken.

Both Dr. Herdman and Dr. Kellogg had noticed some very peculiar physiological effects from the alternating current, and the latter said that he had made some tracings from it which showed it to be a true sinusoidal current.

The President said that he had endeavored in a measure to overcome the uncertainties arising from our faulty momenclature by representing the different currents in the form of medical prescriptions—thus:

℞.—Milliamperes	. . .	practically *nil.*
Volts	. . .	100,000.
Interruptions	. .	one million per second.

This would indicate that a static current was to be used.

℞.—Milliamperes . . . 500.
Volts . . . 30.
Interruptions . . . *nil.*

This represents a constant or galvanic current.

℞.—Milliamperes . . . $\frac{1}{20}$
Volts . . . 500.
Interruptions . . one hundred per second.

This represents a faradic current.

Mr. Carty said, in closing the discussion, that he considered the use of these so-called prescriptions for electricity would materially aid medical men in understanding the nature of the currents they employed, and it was an important practical step in the direction of a more exact nomenclature.

ELECTRICITY AS AN ANÆSTHETIC, by Dr. William F. Hutchinson, of Providence, Rhode Island.

Dr. Hutchinson said that the current from the usual forms of induction apparatus, in which the interruptions are only seven or eight hundred per minute, had failed in his hands to give much relief to pain. He had at one time carried out a series of experiments with the idea of producing anæsthesia by very rapidly repeated blows. By arranging a number of small hammers with elastic handles on a revolving wheel, he had been able to produce rapid percussion, each stroke representing a weight of ten grains, and these strokes being repeated four hundred times a minute. This number of strokes did not materially lessen the sensibility of the part to which they were applied, so the idea of producing local anæsthesia in this way was abandoned. After much experimentation, he had at last succeeded in having constructed for him an induction apparatus, consisting of very carefully measured coils, and having a rheotome made of metallic ribbon, which could be made to vibrate very rapidly. By means of very accurately made imported tuning forks, he had measured the number of vibrations which this rheotome made in a minute, and had found that when this "singing rheotome" sounded the note of C major, representing five hundred and forty vibrations per second, marked anæsthesia was produced; but if the interruptions were made still more rapid, this effect was lost. The change in the number of vibrations is produced by altering the tension on the rheotome; and this tension is so great (seven hundred and forty pounds to each centimeter in length when tuned to C major) that steel was not strong enough; and it became necessary to make the metallic ribbon of phosphor-bronze. Three Burnley cells were used to run the apparatus. By experiments on himself and others, he had found that with the number of vibrations corresponding to A major (five hundred and forty) one minute was sufficient to produce numbness, and on stopping the current there was a rapid return of sensation. An attempt was made then to produce local anæsthesia on a patient suffering from a felon on the forefinger. The finger was placed in a metallic tube partially filled with sponges moistened with salt water. Starting with A major and running up to G major, during a period of three minutes, it was found that the sensibility had been scarcely diminished; but when the rheotome was tuned to C major there was sufficient anæsthesia produced in three minutes to allow of incising the felon without the patient suffering any pain whatever. In a case of *tic douleureux* in which galvanism and Franklinism had both been tried and had proved useless, the induced current from this machine was tried, the rheotome being adjusted to C major, and the negative electrode being applied to the nape of the neck, and

the other to the forehead. In five minutes the pain had sensibly diminished, and in ten minutes it had been completely relieved, and the patient was able to enjoy the first sleep for two days. So far as his experience had gone, every kind of pain yielded equally well to the currents produced when the rheotome was adjusted to C major.

DISCUSSION.

Mr. Carty said he wished to call attention to the fact that the behavior of the current is quite apart from the speed of the interruptor, depending upon various factors, such as the quality of the core, its amount and deposition, and the number of turns of the wire; hence, if disappointing results were met with in the course of such experiments as those described, one should not be discouraged until it had been positively determined that the periodicity of the current agreed exactly with the periodicity of the vibrations of the reed.

Dr. Goelet agreed with Mr. Carty that there is a difference in the character of the current depending upon the quality of the core. He likewise called attention to the influence of the different resistances encountered in medical work upon the physiological effect produced. For instance, the voltage of the current derived from the coarse wire coil is so low that its muscle-contracting power is not appreciable unless the resistance is appropriately reduced, and for this reason its therapeutic value is not fully recognized. He did not think the electrical engineers appreciated our position, since they have to deal only with the resistance of a wire through which the current is directed.

Dr. Nunn said he had been interested in repeating the experiments of Hortimer Granville on the effect of rapid percussion, and although he had not obtained just the same results, he had been led by his studies to state at the last meeting of this Association that pain might be due in some way to an alternation in the vibrations of a nerve. From Dr. Hutchinson's experiments it would appear that the note of C major produces vibrations which neutralize the disordered vibrations in the affected nerve, and if this theory were correct, it did not matter so much about the character of the current itself.

Mr. Carty said that the remarks of the previous speaker had recalled to his mind the fact that when two plates connected with the terminals of a secondary coil are brought close together, they will attract each other, and that on this principle it was not improbable that the current may produce an internal percussion.

This is similar to Dolbear's telephone, and if such a telephone were connected with the terminals, it should emit the same note as that given out by the reed, if the vibrations of the current coincided with those of the reed.

Dr. Nunn replied that when a muscle contracts under the influence of any current, there is undoubtedly a percussion produced.

Dr. Herdman thought a purely mechanical explanation was sufficient to account for the results described in the paper. It is also well-known that musical tones exert a sedative effect upon the nerves.

The President remarked that the suggestion made by Mr. Carty about utilizing the principle of the Dolbear telephone seemed to him a very practical one, for if there be a discrepancy between the vibrations of the rheotome and of the telephone, the former may be so adjusted as to get the desired note from the latter.

Dr. Hutchinson said that unfortunately medical work was full of uncertainties and it was impossible to consider the apparatus apart from the human body; and while he was always pleased to hear a physical explanation, it really mattered

little to the practising physician what the vibrations were, so long as he knew under what conditions he could certainly relieve pain. It seemed probable that the electric current accomplished what mechanical percussion alone could not do, because the percussion was made to reach the affected part. In order to eliminate any possible sedative effect from the musical tones, he had experimented with the apparatus placed in the cellar, so that the patient could not hear the singing rheotome, but the result had been just the same. With the apparatus described, he had been able to produce local anæsthesia with the utmost ease, over an area about one inch greater than the electrode.

ARREST OF HICCOUGH BY PRESSURE ON THE PHRENIC NERVE.

Professor Leloir, of Lille, reports the incident where he was consulted by a little girl, twelve years of age, suffering from an irascible and incoercible attack of hiccough, the spasms occurring every one-half minute, and interfering with sleep and the vital functions of the body, so that it had become apparently a very serious matter to the life of the child. All sorts of remedies were tried until it occurred to him to make compression of the phrenic nerve on the left side between the sterno-clavicular attachments of the sterno-cleido-mastoid muscle. The digital pressure, although painful, was kept up for upward of three minutes, and at the end of this time the hiccough had disappeared, and did not recur. Leloir avers that he has treated many cases of acute and persistent hiccough after this fashion, where the use of every remedy tried has been followed by negative results, and he is quite sure that if the pressure is properly made, and with sufficient force and duration, success will follow.—*Journal of Nerv. and Ment. Dis.*

A CASE OF VAGINISMUS.

A case with characteristic symptoms is reported in the *Med. and Surg. Reporter*, December 24th, 1892. The vaginismus appeared soon after marriage. About five months later the patient came under medical care. The patient's physician writes: When completely anæsthetized, and with the parts thoroughly relaxed, my finger entered the introitus vaginæ without the least resistance. The uterus and vagina were explored, but nothing abnormal could be detected.

Nevertheless, a close ocular inspection revealed the following conditions: The hymen had been lacerated into four distinct parts, each of which was more or less triangular in form. On the apices of each of these, a small hypertrophic nodular mass (like corns on the feet), of the most extreme sensitiveness, was detected. Naturally I resorted at once to the excision of the entire hymen. There was but little hæmorrhage; the resulting raw surface was left to cicatrize. A tampon of unguentum iodoformi was inserted into the vagina, large enough to distend the entire cavity thoroughly. Calling upon my patient the next day, I could realize at once the success of my operation as experienced by her countenance. She could change the tampons and irrigate the parts with but little annoyance, except, as she states, a feeling of slight soreness. The introduction of tampons was continued for about ten days longer. The small wounds healed admirably. There was no more pain. She is now pregnant.

Cyrus, the Persian conqueror, was a wise leader, and, it would seem, pretty wise also on health matters. It is reported of him, when crossing the Choaspes, that he had all the water used for drinking purposes first boiled in silver bowls.—*Ex.*

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BALTIMORE, JANUARY 7, 1893.

Editorial.

ARE PUBLIC URINALS A SANITARY NECESSITY IN OUR LARGE CITIES?

The *Doctors' Weekly*, published in New York City, maintains that every large city should establish a goodly number of public urinals. A writer in that journal estimates that not less than fifteen thousand dollars are daily spent in the liquor-shops of that city by persons who would not enter them except for the privilege obtained of using the lavatories attached to those saloons. Very few of our American cities have provided any public accommodations of this character that will not be found fully patronized, and at some hours of the day over-crowded by the male portion of our population. The female constituency may be said to have been wholly neglected by civic legislation in this regard, but their wants have been passably looked after by the merchants who deal in dry goods.

How undesirable it is for boys and young men to fall into the habit of going into "saloons" for any purpose whatever need not be pointed out. It would be in the interest of good morals if our reformers and public-spirited citizens could see their way to providing an ample number of free urinals. It would be in the interest of good government, also, if our city officials could find it in their line of duty to maintain these conveniences as an incentive to sobriety and cleanly living. The average citizen would be grateful for the chance of relief, even if he did not daily have occasion to avail himself of it; the knowlede that the means of relief existed would of itself be a satisfaction. The only losers by the innovation would be the people who live by the sale of intoxicants. Of the untidy and unsanitary condition of the average saloon "toilet-room" it is not necessary here to say anything.

THE SANITARY VALUES OF A DECEMBER SNOWFALL OR "WHITE CHRISTMAS."

The following extract from the *New York Herald* is timely and interesting to many medical readers:

"The snow storm which in mid-December visited the Atlantic seaboard from Delaware to Massachusetts was peculiarly grateful after the spell of murky weather.

"It has not been noticed by poets or philosophers, at least so far as we have heard, that the snowfall is as benign as it is beautiful, especially at this period of the year, rendered lightless by the short days of the winter solstice. During these dark days the glitter of the snow most happily compensates for the scarcity of sunshine, and more strikingly is this realized when, as the other morning, the trees and all exposed objects are coated with the "glazed frost," or *verglas*, as the French call it.

"The 'treasures of the snow' of which Job speaks are manifold, but none of its charms are greater than its light-reflecting quality, by which it brightens and cheers the gloomy solstitial period of winter in all the dreary high latitudes of the globe. It is not too much to hope that yesterday's snowfall may prove the harbinger of the proverbially healthy and happy "white Christmas" in New York, and elsewhere."

This is one *reason*, speaking from the standpoint of natural religion, why the quality of permanence inheres in the snow. Its brightening influences are felt so much longer, and generally speaking, its duration is proportioned to the latitudes that stand in need of it. Here is food for thought to the country practitioner, as he takes wintry rides along the snow-mantled "pikes" of his circuit.

THE NEED OF NATIONAL QUARANTINE.

John S. Billings, surgeon, U. S. A., writing from Washington, says:

"In reply I would say, in my opinion a system of national quarantine or maritime sanitary inspection can be organized and enforced in such a manner as to afford greater security to the country and cause less restrictions upon traffic and travel than result from the present State and municipal systems. Such a national system would cost more than the present systems, because it would have larger and better plants and better paid officials, but the cost, being defrayed from the national Treasury, would be much more fairly distributed."

Economy, in the face of cholera even now existent in Hamburg, may be said to occupy a "very secondary place" in the minds of the prudent citizen as well as of the experienced sanitarian.

The Northwestern Medical and Surgical Society, which held its twenty-fourth annual meeting at the residence of Dr. Landon Carter Gray on December 21st, has recently issued a publication containing, besides its constitution and by-laws, a brief historical sketch of the society since its organization, in 1869, and a complete list of its members. The officers elected for the year 1893 are: President, Dr. S. Newton Leo; Vice-president, Dr. Robert Milbank; Secretary, Dr. Henry Ling Taylor; and Treasurer, Dr. Frederick Peterson.—*New York Med. Jour.*

Reviews, Books and Pamphlets.

All Around the Year, 1893. Entirely new design in colors by J. PAULINE SUNTER. Printed on heavy cardboard, gilt edges, with chain, tassels and ring. Size, 4¼ x 5½ inches. Boxed. Price, 50 cents. Lee Sheperd, publishers, Boston, Mass.

The "All Around the Year" calendar which Mrs. Sunter sends out this year is as charming a piece of work as anything she has done. Like its predecessors, it is printed on heavy cardboard, gilt edged, with chain, tassels, and ring, and is of convenient size. The designs are fresh and delightful, quaint and picturesque lads and lasses issuing in each month with just the right words, and in the most charming attitudes, while the lines on the cards combine to form a very pleasing love story. Done in several colors, one can scarcely imagine anything more graceful than the twelve cards, each bearing the dainty design which includes the month's calendar as a part of the picture. The cover shows a pretty little Miss watching a Cupid "warming his pretty little toes" at an open fireplace, while on the last page this same Cupid (or his fellow) is playing sweetly "Good-by, my Lover, Good-by."

The Students' Quiz Series. Edited by BERN B. GALLAUDET, M. D., Demonstrator of Surgery, College of Physicians and Surgeons, New York. Volume 13, "Diseases of Children." By C. A. RHODES, M. D., Instructor in Diseases of Children, New York Post-Graduate Medical School. Pocket size, 12mo., 170 pages. Limp Cloth, $1.00. Philadelphia: Lea Brothers & Co., 1892.

Like other issues of the "Students' Quiz Series" the volume on Diseases of Children is written by a thoroughly competent medical teacher in New York and is representative of the latest knowledge. This series as a whole covers the essentials of a thorough medical education, and it enjoys the great advantage of issue under careful editorial supervision. Dr. Gallaudet, the editor, is himself a teacher and practitioner of experience, and is well acquainted with the personnel of his profession in New York. His ability is shown both in the excellence of the matter he has secured, and in the uniformity and attractiveness of its presentation. Students will be greatly assisted by these volumes and likewise physicians who wish to refresh their recollection on important points. Either class will find them most convenient for hand, mind and pocket, the latter in a double sense, since the cost of the books is very low.

The author states in his preface that he has consulted the best authorities, such as Keating's Cyclopædia, and that the intent of his compend is simply to present a summary of the diseases of children which will be useful to tha practitioner as a reminder, after he has carefully read the standard works. We judge that the author has performed his task very well. The volume is neater than most quiz compounds and has an index.

Law of Incorporated Companies Operating Under Municipal Franchises; or Economic Legislation of all the States of the Union. By ALLEN RIPLEY FOOTE and CHARLES E. EVERETT, A. M., LL. B., with a resident attorney in each State as co-editor. In two volumes. Now ready. Price on delivery, $14.00. Address Allen R. Foote, Takoma Park, D. C.

We notice this publication, of which a prospectus has been sent us, first, because some of our readers may find it of value in broadening their views concerning the business side of medicine; and second, because of our friendship for

the author of the Maryland Section, Mr. Arthur Stewart, son of our former Health Commissioner.

Over One Thousand Prescriptions, or Favorite Formulæ of Various Authors, Teachers, and Practising Physicians; the whole being indexed (to diseases) and including most of the newer remedies. Price $1.00; cloth, narrow octavo; 1892. The Illustrated Journal Co., Detroit, Mich.

This volume contains prescriptions which have appeared in *Leonard's Illustrated Medical Journal* during the past five years. There are many blank pages scattered through the volume for manuscript notes by the reader.

Medical Progress.

CHOLERA INJECTIONS.

The operation as performed in Hamburg hospitals is thus described in the *British Medical Journal:*

The apparatus used consists of a glass jug, holding rather more than a litre (35 ounces) of solution; to it is attached an indiarubber tubing, eight feet in length, interrupted by a few inches of glass tubing and a stopcock; at the other end of the indiarubber tubing is a silver cannula. The irrigator is placed at different heights according to the pressure desired. This hospital is supplied with galvanized iron stands, six feet high, in which the glass vessel is fixed; but hundreds of wooden stands have been improvised to meet the present emergency.

The forearm having been well sponged with pure ether, the vein is laid bare and its distal end tied with a catgut ligature. Another ligature ready for tying is passed beneath its proximal end. An opening is then made of sufficient size to admit the cannula, which is inserted some three or four inches in the vein, and the second ligature tightened upon it. Sometimes the fluid infuses very slowly, there appearing to be an obstruction, but generally the necessary quantity is rapidly absorbed. From one to two litres of the solution may be infused into an adult patient; from ten to twenty ounces for a child. It is considered wiser in all cases to commence with the smaller quantity. The temperature of the solution is 101° or 102° F. when placed in the irrigator, as it cools in the transit. After the infusion is completed the cannula is withdrawn, the second ligature tied, and the wound dressed with folds of iodoform gauze, iodoform bandage, and plain gauze bandage. When necessary, the infusion is repeated as many as four or five times. If the patient be severely collapsed a hot pack follows closely on the infusions. The patient is immersed for three or five minutes in a bath at a temperature of 103° F., and afterwards closely wrapped in blankets for an hour.

WHY DO URETHRAL STRICTURES RELAPSE?

Writing in the *Lancet*, November 12, Dr. Mouillin says: In regard to those strictures in which there has been no breach of surface of any size, close observation of a considerable number has convinced me that a certain proportion can be cured permanently by adopting suitable methods and maintaining the treatment for a sufficient length of time. The cause of their contracting originally is different. It is not now the presence of a scar due to a loss of surface, which nothing but transplantation can replace; it is merely the slight persistent irritation kept up by the passage of the urine over a tender part of the urethra. At first the progress of the stricture is exceedingly slow, the irritation is very slight

and the amount of lymph effused very small, scarcely making a perceptible difference in the calibre of the urethra even at the end of months; but as years pass by this fractional amount accumulates and grows harder, the obstruction becomes more marked, the straining and irritation it causes more severe, and the amount that is poured out larger and larger until at length it forms a dense mass, filling the interstices not only of the mucous and submucous layers, but those of the corpus-spongiosum and bulb as well, growing harder and more rigid with ever-increasing rapidity the longer it lasts; and it is for the same reason, and not because there is a scar, that these strictures relapse so often after treatment. The whole of the obstruction is not dispersed; some, ever so little it may be, is left, and sooner or later the same old vicious circle begins again, the obstruction causing irritation and the irritation making the obstruction worse. Unless the whole is removed and the lining membrane of the urethra restored to its natural flexibility there can be no permanent cure. How this is to accomplished varies naturally with the kind of stricture; but whatever the treatment adopted, whether it is division or dilatation, it must always be borne in mind that this is only a preliminary. Dilatation may stretch and urethrotomy may divide the rigid lymph, but neither really does away with the obstruction. It is diminished so that there is no straining and much less irritation during micturition, but that is all. The stricture tissue is still there; complete removal can only be effected by the very slow process of fatty degeneration and absorption, and for this it is absolutely necessary that there should be a long period of perfect rest and freedom from all spasm and irritation. How far this can be secured by dilatation alone is very doubtful. It may succeed if the stricture is very recent and still confined to the walls of the urethra, but if there is already a large amount of peri-urethral infiltration it is almost useless, except as a temporary measure; and if the stricture is old and hard, whether confined to the mucous and submucous coats or not, it is scarcely any better, even though it is carried to the point of extreme distension. The lymph is stretched, a great deal of it disappears and the muscular fibres that surround the urethra are paralyzed for a time; but in a very little while after the catheter is withdrawn the contraction begins again. The tenderness and irritability are still there; the tone of the muscular fibre returns and as soon as the stream of urine begins to unfold and open out the walls of the canal the stimulus sets up a slight but sufficient degree of contraction. So long as the stricture is wide the obstruction this causes is scarcely perceptible; the hyperæmia passes off almost at once, and there is so little exudation that the occasional passage of a catheter is sufficient to keep the channel dilated; but if the case is neglected, little by little the lymph collects until at length, when the contraction has passed a certain point, further progress is by leaps and bounds. For a long time I have practised internal urethrotomy after thorough dilatation, with the view of preventing muscular spasm and giving a long period of perfect rest for the removal of the last of the exudation; and although it is difficult to prove, I feel convinced that this method has met with a higher degree of success than either dilatation or internal urethrotomy by itself. Internal urethrotomy without previous dilatation succeeds sometimes, just as simple dilatation does in recent cases in which the stricture tissue is confined to the walls of the urethra, but not in those in which the exudation is old and hard, or very widely spread; absorption is too slow. The muscular fibres are divided so that there is no spasmodic contraction; but division, however thorough it is, does not restore the parts to their natural state. The expansion of the urethra when the urine passes down it is not smooth or even until the whole of the exudation has been absorbed; and this takes too long. Be-

fore the old and hardened lymph has had time to disappear completely the obstruction and irritation that it causes have led to a fresh deposit and the narrowing has commenced again. Unless the stricture is a recent one, and the exudation comparatively soft, dilatation is always necessary after internal urethrotomy—at any rate, for a time. Ocasionally, if it is kept up diligently for some months and gradually left off, no recontraction takes place. External urethrotomy, on the other hand, practically fulfils all the required conditions, and to this it owes its success in some of the very worst cases. The whole of the urine escapes without tension or straining; muscular spasm is out of the question; however hard or widely spread the exudation, the whole of it must soften and melt away before the wound will close. Meanwhile the channel regains its natural size and the walls their flexibility. The rest that it gives is perfect, and certainly in some instances absorption is complete and the cure permanent; a fact that deserves more attention than it has hitherto received, for this method of treatment is rarely given an opportunity except in cases in which every other measure, including dilatation and internal urethrotomy, has been tried and has failed time after time.

RETINAL SYMPTOMS OF CHRONIC BRIGHT'S DISEASE AND DIABETES.

The following classification of these retinal affections is abstracted (*British Medical Journal*, December 17th) from the Middlemore Lectures of Dr. Robert Saundby, of Birmingham:

CHRONIC BRIGHT'S DISEASE.

1. Diffused opacity.
2. White patches: (*a*) Rounded soft-edged areas generally situated near the disc, and (*b*) smaller, brighter, often radiated specks generally near the yellow spot.
3. Hæmorrhages.
4. Optic papillitis.
5. Diffuse retinitis.
6. Secondary atrophic changes.
7. General retinal periarteritis.

General retinal periarteritis was included in this classification because although not solely, it was usually associated with Bright's disease, and had therefore as much claim to be regarded as one of the retinal affections met with in Bright's disease as any of the forms more usually recognized.

The pathological explanation of all these changes was sought in the dyscrasia, which set up, first, nutritive disturbances, and secondly, inflammatory and degenerative changes in the tissues. The minute histological details of each were fully described. The course of the inflammatory lesions was shown to be not necessarily hopeless of cure, though more or less permanent structural change might remain; even the degenerative spots sometimes disappeared; cases illustrating these facts were quoted. The difficulty of assigning any absolute diagnostic value to these appearances was pointed out and illustrated by drawings and cases.

On the other hand, the prognostic meaning of the degenerative white specks (*b*) of diffuse neuro-retinitis, and of general periarteritis in otherwise well-assured cases of Bright's disease, was well-defined and of the most serious character. The lecture was illustrated by a number of diagrams and by microscopical preparations kindly lent by Mr. E. Treacher Collins, Mr. Lawford, and Mr. Priestley Smith.

DIABETES.

After a brief historical introduction the lecturer described the retinal affections of diabetes in accordance with Hirschberg's recent classification.

1. Retinitis centralis punctata diabetica, in which there is a characteristic inflammation of the central portion of the retina, giving rise to the appearance of bright spots, often coalescing and frequently accompanied by hæmorrhages.

2. Retinitis hæmorrhagica diabetica, in which the essential process is hæmorrhage followed by inflammatory and degenerative changes.

3. Mixed cases.

The disease in all its forms occurs only in persons of middle or advanced life, and in cases of diabetes of some standing. It is generally bilateral and causes disturbance of vision, the patients complaining of a mist before their eyes. In the first form the ophthalmoscope reveals groups of small, clear, bright specks situated in the structure of the retina, in and around the disc, occurring on the nasal as well as the temporal side, never radiated in arrangement but often occupying large areas, never pigmented, but accompanied by fine punctiform hæmorrhages. It is never attended by optic papillitis or diffuse retinitis. Newly formed blood vessels have been observed, and there is a decided tendency to the occurrence of large hæmorrhages into the vitreous. This description was illustrated by a case, and the fundus oculi shown by means of Mr. Priestly Smith's demonstrating ophthalmoscope.

The pathology of the affection was held to be dependent on the diabetic dyscrasia which leads to nutritive changes in the walls of the vessels, and to the effusion of albuminous material into and between the layers of the retina. In the second form the hæmorrhages are usually punctiform, but may be striated, and are situated all over the retina; their source is not the superficial retinal vessels, and their rounded shape indicates that they are situated below the nerve fibre layer. There may be haziness of the retina depending on some degree of œdema. The hæmorrhages are due to vascular degeneration, caused doubtless by the dyscrasia, but the histological details have not been worked out. The course of both is progressive, and no instance of recovery has been recorded, although temporary improvement in vision occasionally takes place.

The first form is highly characteristic when well marked, but the diagnosis should always be confirmed by examining the urine. Little is known definitely as to the prognostic importance of either, but on general grounds it is probable that they indicate an advanced degree of those nutritive derangements which herald a fatal termination.

Medical Items.

A series of tests by Pfuhl on the dejecta of cholera patients showed that, mixed well with an equal quantity of milk of lime, the bacilli were entirely destroyed in less than one hour. By merely adding the lime, which sank to the bottom, the bacilli were destroyed but in part.—*Sanitary Era.*

MM. Saint Yves Ménard and E. Chambon have observed that when accidentally they used during four or five weeks vaccine prepared in glycerine the pustules were more perfect than when fresh glycerine was used. On systematically testing this point they ascertained that pulp 15 days old produced moderately-developed pustules. Pulp of 40, 50, or 60 days produced typical pustules.—*Ex.*

We have received a card from the superintendent of the Johns Hopkins Hospital, Dr. Hurd, stating that physicians, resident in the city, are cordially invited to attend three lectures by Dr. John S. Billings, Surgeon U. S. Army, on the "History of Medicine," in the Clinical Amphitheatre, on Monument Street, at 4.30 P. M., Mondays, January 9, 16 and 23, 1893.

A series of meetings is being organized at the Bourse du Travail in Paris to regulate the work of children, young girls and women serving in shops, bazaars and houses of business. A meeting attended by 600 girls and women has already been held. Resolutions were passed that girls and women should not be compelled to work more than eight hours a day, with one day's rest. Working at night and over hours ought to be forbidden; and no work should be required for six weeks before and six weeks after delivery. Standing to sell outside shop doors should also be forbidden. Seats should be provided for shop girls.—*Ex.*

So many accidents of a fatal nature arise from imprudence in searching for a "gas leak," that we have obtained authoritative advice. It comes in the following form: In "case of any escape of gas I would advise the immediate turning off of all gas from the premises by means of the main cock, always placed near the meter, then opening doors and windows to allow the accumulated gas to get away, and immediately sending for a gas fitter, or one of the company's inspectors, seeing, of course, that no lights or fires are going. I would no more advise a householder how personally to search for an escape of gas than I would advise him how to doctor himself or repair his watch." This is the opinion with which we are favored by the distributing engineer of a great gas company.—*British Medical Journal.*

The Medical Society of Washington County will meet in regular session on Wednesday, January 11, at 11 o'clock A. M., in the hall of the Society, Y. M. C. A. building, West Washington Street. Dr. C. L. G. Anderson will read a paper having for its subject "Peach Fever." Dr. H. C. Foster will read a paper upon "A Case of Fracture of Forearm Resulting in a Suit of Malpractice." Dr. H. S. Herman will read a "Report of a Case of Pneumonia." The subject for general discussion is "Abortion, its Causes and Management." J. W. Humrichouse, Corresponding Secretary, A. S. Mason, M. D., President.

There is said to be on file in the Patent Office, at Washington, dated about forty years ago, an application for a patent for a trap for the removal of tape worms from the stomach and intestines without employing medicine. The invention consists in a non-corrosive metallic trap, which is baited, attached to a string, and swallowed by the patient, after a fast of suitable duration, to make the worm hungry. The worm seizes the bait, and its head is caught in the trap, which is then withdrawn from the patient's stomach by the string, which has been left hanging from the mouth, dragging after it the whole length of the worm.—*Ex.*

Professor Tommasi-Crudeli has no faith at all in the alleged anti-malarious influence of the salicylates, and attaches hardly any greater value to the use of eucalyptus. He also disputes the alleged beneficial results said to have attended the planting of eucalyptus trees in malarious regions. He thinks much more highly of a popular remedy widely employed in many parts of Italy, Greece, Arabia, the West Indies &c.—viz., preparations of the lemon tree. The most active preparation is said to be a decoction of the whole lemon fruit, and remarkable results are claimed for this cheap and simple remedy.—*Lancet.*

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Original Articles.

THE NECESSITY OF FINDING THE CAUSE OF RECURRENT EARACHE WHICH SUBSIDES WITHOUT APPARENT INJURY TO THE EAR.*

BY HIRAM WOODS, M. D.,

Of Surgical Staff at the Presbyterian Eye and Ear Hospital; Professor of Diseases of the Eye and Ear at Woman's Medical College, Baltimore.

No physician of considerable practice can have failed to have patients consult him on account of recurring earache. In some cases the pain comes in paroxysms of two or three hours' duration; disappears, sometimes spontaneously, sometimes only after the use of hot applications and anodynes; and returns after a long or short interval. Again, there are no distinct paroxysms of pain. The individual is conscious now and then that his ear hurts him. It never confines him to the house and he may make only an incidental allusion to it when he happens to feel a pang, or thinks of the matter when with his physician. While by no means always so, the first class is usually made up of children, the second of adults. One will find, I think, that the subsequent histories of such cases divide them into three groups: (1) those who "outgrow," as it is called, the earache, or at at any rate cease to have the attacks, and retain good hearing; (2) those who continue to have occasional paroxysms, or else now and then feel a twinge of pain, without the development of any special symptoms, save a slight,

*Read before the Medical and Chirurgical Faculty of Maryland, at Easton, November 15th, 1892.

and possibly transient, defect in hearing; (3) those who after an attack of earache have a serous or purulent otorrhœa. This may subside and leave the ear still useful, but nevertheless impaired; or it may become chronic.

Thus earache may be a trivial matter. Again, it may be a symptom of an inflammation, which will soon show itself by a discharge; or else be the only appreciable indication of conditions which can cause slow changes in the ear and lessen its usefulness. If the diagnosis "earache" be looked upon as good and sufficient, and therapeusis be limited to relieving the patient's suffering, *possibly* no harm will be done; but in the majority of cases important things will be overlooked, and harm will result. The object of this paper is to make a brief study of these cases of earache with special reference to their effects and causes. Barring furuncular and diffuse inflammation of the external auditory canal, painful affections of the ear are due, usually, to catarrhal inflammation of the tympanic cavity, or to reflex neuralgia of the ear from some cause outside of the ear itself. Canal inflammation generally shows itself clearly enough and need not be considered. Of catarrhal inflammation of the drum cavity, many cases pursue the typical course of hyperæmia of the tympanic mucosa, exudation into the drum cavity, perforation of the drumhead, and the establishment of an otorrhœa. Pain is the most prominent symptom of the stages of hyperæmia and exudation, and is relieved when the drumhead ruptures. But all cases do not go so far as perforation. There is hyperæmia of the tympanic mucous membrane, and examination of the ear with the head-mirror, reflected light and ear speculum reveals the vascular changes in the drumhead characteristic of acute aural catarrh; but there is never the bulging of the drumhead indicative of exudation, hearing may not be greatly impaired, the drum can be inflated through the Eustachian tube, and the trouble does not go beyond the stage of hyperæmia. There are a great many such cases of abortive acute aural catarrh observed in an aural clinic. Tympanic hyperæmia may occur once or twice as the result of cold or exposure, and subside without serious results; but when it occurs again and again two things become manifest: (1) the usual results of repeated hyperæmia will probably ensue in the tympanic cavity, and (2) there must be some cause of these attacks more or less closely connected with the ear. That acute catarrh of the tympanum is the most common cause of the repeated earaches frequently observed in children is the opinion of such authors as Woakes, Roosa and Buck; but the pain soon subsides, the hearing continues good, and nothing more is thought of the matter till the next attack. If more care were taken to make the tests, there is little doubt but that the hearing of ears which have passed through two or three such attacks would be found impaired. Still, as one can lose nearly one-half of the normal hearing power without being specially inconvenienced, the slow deterioration is not noticed for a long time. This gradual lessening of the hearing power after repeated tympanic hyperæmia is the result of connective tissue formation in the mucous membrane covering the walls of, and ossicles in, the drum cavity. The ossicles become adherent to

the walls of the cavity at the points where they touch, the joints between the ossicles become anchylosed, and so the power of conducting sound-waves to the nervous ear is lessened.

Again, as this thickening advances, the tympanum becomes less able to withstand fresh attacks, and so an otorrhœa is apt to eventually result with all its attendant inconveniences and perils; nor do the dangers from tympanic catarrh, not diagnosticable except by objective examination, and presenting only symptoms of severe pain in the ear, stop at the point mentioned. Such attacks are very common among infants. Woakes thinks convulsions are often caused by pressure upon the labyrinth, from an exudation into the tympanum due to an acute aural catarrh. resulting from dentition. He, Politzer and others describe a fold of the meninges, which in infancy passes through the petro-squamosal suture into the drum. Cases of fatal meningitis may thus develop before the tympanic inflammation has caused rupture of the drumhead. While such results may be rare, certain it is that the ultimate production of a foul otorrhœa in infants after one or more neglected attacks of earache during dentition is a common occurrence. Possibly the ear is not thought of as a source of pain, until the appearance of the discharge. Deaf-mutism can thus result if the hearing becomes greatly impaired before speech has been learned, even if the child escapes the more fatal dangers of an otorrhœa.

Having thus reviewed some of the consequences of tympanic catarrh, of which *pain* is usually the only symptom, I beg to lay stress upon the facts that earache is only a *symptom;* that diagnosis must extend to the discovery of its cause; that if this cause, in turn, is due to other abnormal conditions, they must be found; that the therapeusis of earache, especially recurring earache, must go further than the relief of pain. There is not the space in the limits of this paper to enter into the therapeusis of tympanic catarrh, appropriate as such a course might be. To some of its causes, too frequently overlooked, I desire to direct attention.

Chronic abnormalities of the naso-pharynx are a prolific cause of tympanic catarrh. Follicular pharyngitis, post-nasal vegetations and hypertrophied tonsils are, in my experience, the most common throat lesions observed in connection with recurring earache. It is, I think, a more or less common belief that, if chronic follicular pharyngitis does not cause so much throat discomfort as to call attention to itself, or if post-nasal adenoid vegetations do not interfere with nasal respiration, these troubles may be left alone. That they can produce deafness and recurring hyperæmia of the tympanum without special throat or nasal symptoms, I do not think admits of doubt. Situated, as they often are, near the pharyngeal mouths of the Eustachian tubes, these inflamed follicles or vegetations act as irritants, increase the vascularity of the tubes, and cause an Eustachian catarrh. This can reach the tympanum by direct continuity of mucous membrane. Again, as soon as ventilation of the tympanum through the Eustachians is hindered, and the air already in the tympanum has been absorbed—no renewal taking place through the tubes—atmospheric pressure in the external

canal drives the drumhead inwards, producing undue pressure upon the ossicles. Impairment of hearing and tinnitus usually follow at once. If unrelieved, hyperæmia and pain follow. Relief comes as soon as the Eustachians again admit air to the drums. Inflation by Politzer's method promptly removes the ear symptoms and the application of a nitrate of silver solution to the mouths of the tubes lessens the secondary catarrh; but it will surely return, unless the primary trouble is removed. As regards enlarged tonsils, their importance from an otological standpoint has been exaggerated. Probably they rarely occur unaccompanied by other morbid conditions of the throat, which more immediately affect the ear. By lessening the air-space, they may, indeed, produce these conditions. This will certainly be the case if they interfere with nasal respiration. The same is true, however, of any conditions which block the nostrils. Mouth-breathing is a well-known cause of pharyngeal disease, and when nasal respiration is impeded in persons suffering from ear symptoms, it should be re-established. Still, so far as the *direct* influence of hypertrophied tonsils upon the ear is concerned, Roosa states that it is doubtful if they ever enlarge to the extent of pressing upon the mouths of the tubes. He advises their removal upon the grounds I have advanced: that they may "affect the health of the pharynx." I have seen patients cured of middle ear disease by the removal of post-nasal vegetations, although hypertrophied tonsils were also present. Another source of danger to the ears from naso-pharyngeal disease is direct microbic invasion through the tubes. This undoubtedly occurs.

Occasionally one will observe a patient who has carache, and possibly defective hearing, and find one or more of the throat lesions mentioned, but the examination of the ear will be negative. The drumhead does not present any increased vascularity. Evidently there is no tympanic inflammation. The pain is not so severe or lasting as in tympanic catarrh. It is felt as a shooting neuralgic pain in the ear. I have had under my care two sisters who have shown this condition. One consulted me for occasional attacks of deafness and earache some time ago. I reported her case in the MARYLAND MEDICAL JOURNAL, of December 26, 1891, in an article upon post-nasal vegetations as a cause of deafness. I frequently examined her ear when painful, but there was no inflammation. When I removed the vegetations with Mackenzie's forceps, she experienced severe pain in both ears. Her sister has follicular pharyngitis and tonsillitis. Earache with her is not a marked symptom, but her hearing has been poor. I have, however, often produced an otalgia, or ear neuralgia, with her by simply pressing the tonsils with a probe, or applying an applicator to the naso-pharynx.

I experienced myself last spring a definite and painful proof of the power of throat disease to cause reflex earache without inflammatory changes. I was suffering from an attack of acute tonsillitis on the left side. The afternoon of the second day, my left ear gave me some pain. This steadily increased until by night it was agonizing. I obtained some relief from anodynes, but very little. I could still hear fairly, and could inflate the drum through the Eustachian.

Early in the morning I sent for Prof. Chisolm. I feared that he would find an acute aural catarrh. Greatly to my relief he did not. His words were: "It is reflex. The drumhead is not even congested." The correctness of his diagnosis was proven by the sequel. I obtained some relief from the large doses of salicylate of sodium he ordered, but the pain did not cease till my tonsil was well. No ear trouble followed. These cases prove, I think, the power of throat lesions to produce a purely neuralgic earache. Whether or not this reflex can eventually cause organic lesions in the ear, I am not prepared to say; still, they bring us straight back to my theme—the necessity of finding the cause of earache. In the cases of the two sisters mentioned, the causes were of themselves capable of damaging the ears through the Eustachians. The channel of transmission in these cases was almost certainly the glosso-pharyngeal nerve, which supplies the tonsils, pharynx and tympanum with sensory fibres.

The teeth, and more particularly dentition, constitute a source of ear disease which is not sufficiently appreciated. The occurrence of otorrhœa in babies during dentition is frequently observed. Earache in infants, I am sure, is not always recognized as promptly as it should be. I see babies with otorrhœa whose clinical history is very clearly read backwards from the otorrhœa to dentition, but the pain the little one then had in the ear was not attributed to that organ. I have now a little patient nineteen months old, who first had otorrhœa when one year old, the sequel of measles. Both ears are affected. Twice have I succeeded in stopping the discharge, and twice has the boy had a relapse, each time at the cutting of a new tooth.

Sexton, of New York, who has given the subject of oral irritation careful study, considers irritation from the mouth a most prolific cause of ear disease. He goes so far as to condemn amalgum fillings, vulcanite plates, and retention of teeth which have lost their nerve pulp as dangerous to the integrity of the ears. I have tried to make some clinical observations upon this subject. While I have seen nothing to lead me to accept all Sexton says, I have over and over again seen earache, sometimes accompanied by hyperæmia of the drumhead, and sometimes not, cured only after a carious tooth had been removed, or cleaned out and filled.

The channel of transmission from the teeth to the ears may be directly through the fibres of the fifth from the dental to the auriculo-temporal branch. This may be the case in those patients whose trouble is only *pain* of a reflex character, unaccompanied by inflammatory changes; but it will not explain the acute aural catarrh and suppurative otitis of dentition. Two explanations of these lesions are given: (1) extension of the inflammation from the gums to the middle ear by direct continuity of tissue. Roosa says he has seen this. Woakes, on the other hand, holds that the intermediate tissues are healthy, and offers, as an explanation of the tympanic catarrh, vaso-motor disturbance. He traces the irritation from the teeth along the afferent sympathetic fibres accompanying the dental branches of the fifth to the otic ganglion. Here the nervi vasorum of the

carotid plexus are met and receive reflex irritation. This causes dilatation of the tympanic branch of the internal carotid going to the drumhead. Thus a hyperæmia of the drumhead is produced. Its vessels anastomose freely with those of the drum cavity, and tympanic hyperæmia results—the first step in the production of tympanic catarrh.

Justifiable conclusions from the foregoing are that the diagnosis in cases of recurrent earache must include the condition of the drumhead, pharynx, nose and teeth; that therapeusis must include the treatment of disease found in these structures.

525 N. Howard Street.

RUPTURE OF THE ABDOMINAL MUSCLES IN NORMAL LABOR.*

BY J. W. HALLUM, M. D., CARROLLTON, GA.

This case, to me, if not the medical profession, is one of very rare occurrence, and if you should be so unfortunate as to come in contact with a case of this kind, I do not doubt that you will be more interested than from my report.

On June 23rd, 1892, I was called to see Mrs. G—, primipara, aged 16 years, who had been in labor ten hours; found her in second stage, and everything (except the pains) indicated a speedy delivery, the cervix being fully dilated. I made only the usual digital examination. After waiting an hour and finding no increase in the pains, I gave thirty drops Squibb's fld. ext. ergot, and repeated the dose in half an hour. The two doses failed to produce the usual results—no increase in pain or advancement of the child.

I then made a closer examination and found a large fluctuating tumor on the "belly" somewhat below (and entirely so when the feeble pains came on) the navel, and lying between the abdominal muscles and the skin. The tumor contained about three quarts, and was a formidable looking object on a pregnant woman's "belly."

When the muscles were relaxed I found the recti separated from near the ensiform cartilage to within one and one half inches of the symphysis pubis.

I then called Dr. J. C. Brock, but we were not certain as to what the tumor contained. The lady informed us that it appeared only a few hours before I came, and that up to that time her pains were very hard, when they almost ceased and remained so until I arrived.

Dr. Brock introduced a catheter into the bladder and to our surprise the tumor disappeared entirely, after we had drawn three quarts of urine, and has never made its appearance any more. The bladder had undoubtedly escaped below the abdominal cavity, through the rent.

After the urine was drawn she was soon delivered of a living child. Both did well except that the woman had more soreness of the abdomen than is common;

*Read before the Tri-State Medical Society, Chattanooga, Tenn., October 26th, 1892.

so much so that it required several doses of Dover's powder each day for two first days following labor.

The muscles are still separated, and when the woman is lying on her back the muscles relax and separate at the navel about four inches, allowing a large mass of the intestines to protrude, which we might call a hernia; but when she gets up or otherwise contracts the recti muscles they force the bowels back, and so completely close the rent that it is difficult to find at all, and it could not be found if the patient were standing. The lady is naturally quite lean and you can very easily handle any of the organs in the abdominal cavity.

This woman is only sixteen years old and is enjoying very good health, and the probability is that she will become pregnant again; if so, what am I to do? what should I do beforehand?

I have closely observed the action of these muscles and from the way they behave I am satisfied that when the gravid uterus enlarges until its antero-posterior diameter a little more than doubles the antero-posterior diameter of abdominal cavity, then the muscles instead of closing together in front of the uterus will naturally close behind it on account of the uterus' convex-posterior surface. I do not think that bandaging could prevent it.

The rent must be closed or pregnancy prevented.

I do not feel sure that a surgical operation would unite these muscles strongly enough to prevent them being separated at her next confinement; yet I am satisfied that it would enable her to carry her child to term.

It has been suggested, and I fully agree that the best way of closing this rent would be to incise the skin and fascia the entire length of the rent, and cut away part of the fascia and suture the muscles together without opening the abdominal cavity or even piercing the peritoneum with a needle.

Unless the muscles can be united, I think I would be justifiable in preventing pregnancy or in *producing an abortion* in case of pregnancy.

A UNIQUE METHOD OF TREATMENT FOR HÆMORRHAGE FROM THE BOWELS IN TYPHOID FEVER.

A unique method of treatment for hæmorrhage from the bowels in typhoid fever is that of "tieing off" the limbs, now in use in New York hospitals with most beneficial effects. This consists in passing an elastic band with a buckle on it (a piece of suspender will answer admirably) around each of the limbs close to the body. These are tightened sufficiently to check the venous return and yet not obstruct the arterial flow, thus keeping a large amount of blood out of the trunk, and thereby greatly lowering the pressure in the intestines. At proper intervals, to be determined by the condition of the limbs, one band at a time is loosened sufficiently to permit free circulation for about ten minutes, and then tightened again. This is continued for several days, depending entirely on the severity of the hæmorrhage.—Dr. Tuttle, *Southern Medical Record.*

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BALTIMORE, JANUARY 14, 1893.

Editorial.

THE JOHNS HOPKINS MEDICAL SCHOOL.

Miss Mary Elizabeth Garrett has made possible the opening of the proposed medical school of the Johns Hopkins University, in which women shall receive the same opportunity for study as men. The School, by vote of the University trustees, will open in October, 1893. Miss Garrett has placed at the disposal of the trustees $306,977, which, with the amount already in hand, will make up $500,000, the sum which was required by the trustees to be made available for the medical school before its establishment was to become a fact. The gift is to be called "The Mary Elizabeth Garrett Fund." It does not represent all that Miss Garrett has given, for she contributed $47,787.50 to the fund raised by the committee of Baltimore women toward the fund of $100,000 required by the trustees before women could be admitted to the medical school. According to the terms of Miss Garrett's gift, the money is to revert to her or her heirs if the university shall discontinue a medical school devoted to the education of both men or women, or if at any time it can be shown by proper legal proceedings that the women studying in the medical school do not enjoy all its advantages on the same terms as men or not admitted on the same terms as men to all prizes, dignities or honors that are awarded by competitive examination or regarded as rewards of merit, and with certain further stipulations, as follows:

Other conditions of the gift are:

"1. That not more than $50,000 of the original endowment of $500,000 shall be expended on a building or buildings, and that in memory of the contributions of the committees of the Women's Medical School Fund this building, if there be but one, or the chief building, if there be more than one, shall be known as the Women's Fund Memorial Building.

"2. That the medical school of the university shall be exclusively a graduate

school as hereinafter explained, that is to say: That the medical school of the Johns Hopkins University shall form an integral part of the Johns Hopkins University, and like other departments of the university, shall be under the management and control of the trustees of the said university; that it shall provide a four years' course, leading to the degree of doctor of medicine; that all the instruction given in the school shall pre-suppose the knowledge at present required for matriculation in your university and the knowledge imparted in the preliminary medical course (*Third Group,* Chemical Biological) as at present laid down in your university register; that there shall be admitted to the school those students only who by examination or by other tests equally satisfactory to the faculty of the medical school (no distinction being made in these tests or examinations between men and women) have proved that they have completed the studies included in the preliminary medical course (but this condition is not meant to restrict the trustees from receiving as hearers, but not as candidates for the degree of doctor of medicine) those who have received the degree of doctor of medicine or its equivalent in some school of good repute, and that the degree of doctor of medicine of the Johns Hopkins University shall be given to no doctors of medicine who have not proved by examination, or by other tests equally satisfactory to the faculty of the medical school, that they have completed the studies included in the preliminary medical course, besides completing the course of instruction of the medical school of the Johns Hopkins University.

"3. That the terms of this gift and the resolution of October 28, 1890, in which the trustees accepted the gift of the Women's Medical School Fund, shall be printed each year in whatever annual or semi-annual calendars may be issued announcing the courses of the medical school.

"4. That there shall be created a committee of six women to whom the women studying in the medical school may apply for advice concerning lodging and other practical matters, and that all questions concerning the personal character of women applying for admission to the school and all non-academic questions of discipline affecting the women studying in the medical school shall be referred to this committee, and by them be in writing reported for action to the authorities of the university; that the members of this committee shall be members for life; that the committee, when once formed, shall be self-nominating, its nominations of new members to fill such vacancies as may occur being subject always to the approval of the board of trustees of the university, and that the first members shall be Mrs. Henry M. Hurd and Mrs. Ira D. Remsen, both of whom were active members of the Baltimore committee of the Women's Medical School fund; Mrs. William Osler; Miss M. Carey Thomas and Miss Mary M. Gwinn, the two friends who have been most closely associated with me in promoting the opening of the medical school, both of whom are daughters of trustees of the university; and myself.

"5. That the medical school shall be opened in the autumn of 1893, and that notice of such intended opening shall be given on February 22, 1893.*

*For these Statistics we are indebted to the Baltimore *Sun.*

VIVISECTION AND HUMAN LIFE.

The following letter, sent to the London *Echo,* is a suggestive item drawn out by the newspaper discussion of vivisection that has been going on for two or three months, especially in the London press:—"Sir: It is amusing, but pathetic, to notice the distress of spirit amongst some of the good people who write to you to protest against vivisection. Vivisection is but a drop in the ocean of mundane torture and misery. There is so little sanctity visible about human life that one marvels at any attempt to identify the principle with the life of the lower animals. *What can be more ineffably cheap and common than the life of humanity to-day?* Everywhere one sees a huge torrent of infant life poured into the world, for the most part in as apparently accidental, promiscuous and haphazard a way as can well be imagined. Where is the boasted dignity of manhood and womanhood in a world where men and women are cheaper and more plentiful than horses and oxen, and, in many instances, not held in half such esteem? Perhaps some optimistic correspondent can explain.—Yours, &c., PERPLEXED."

When human life is held so "ineffably cheap" as it is to-day in even the most refined centres of civilization—saying naught of the ceaseless cruelties practised upon women and children among the ruder peoples of the earth, why all this ado about the quantity of anæsthetics given to a dog or guinea-pig? Who is there who can take up cudgels in this cause and yet not admit, upon reflection, that he is giving up his time and energy to a rank sentimentalism? We have the impression that the same type of mentality that takes kindly to infinitesimals in medicine is fitted to take part in the anti-vivisection attack upon rational research in physiology and pathology. As so well expressed in the above letter, "vivisection is but a drop in the ocean of mundane misery;" and still it is a drop not ruthlessly shed by the studious medical man. The hand that would attach the label "cruelty" to the medical investigator is in truth blood-stained although it wear a white glove. And this for the reason that if the anti-vivisection cause should become a success, human suffering would of necessity be increased. Not a few of these same sentimentalists are in the ranks of the anti-vaccinationists, by whom the sum of "mundane misery" has been increased in no light measure.

Sir Andrew Clark has recently expressed his opinion to the effect that if experimental investigation were suppressed and the knowledge thus acquired rejected, both physical and mental degeneration would follow, and science in England would become the pity and contempt of the world. —P.

We find in the *North-western Lancet* a more reasonable explanation, supported by facts, of the sudden drowning of good swimmers, hitherto attributed to cramp. There is nothing in a cramp in a leg to prevent an ordinary swimmer supporting himself in the water by his hands, or on his back, nor to cause him to throw up his hands and sink once for all like a stone. The cause is attributed to perforation of the ear drum, through which the access of water pressure occasions vertigo and unconsciousness; and a practical caution results, to persons having such perforations, to protect their ears with a stopper of cotton when bathing.—*Sanitary Era.*

Society Reports.

TRANSACTIONS OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

SECOND ANNUAL MEETING, HELD IN NEW YORK, OCTOBER 4, 5 AND 6, 1892.

SECOND DAY, OCTOBER 5, AFTERNOON SESSION.

SOME PHYSIOLOGICAL EXPERIMENTS WITH MAGNETISM AT THE EDISON LABORATORY, by Dr. Frederick Peterson, of New York, and A. E. Kennelly, Esq., of the Edison Laboratory.

The writers, after citing several medical authors in regard to the claims made for the therapeutic action and powers of the magnet, described a series of experiments which they carried out with a view to ascertaining whether or not these claims were well founded. Mr. Edison placed at their disposal magnets of enormous power. The one employed in these experiments measured 1½ by 2 feet, and required two men to lift it. Between the large poles of this magnet were placed objects for examination. A drop of water, when placed in the magnetic field on a glass slide, was visibly distorted by the magnetic force, and iron by hydrogen behaved just like iron filings. It had no effect, however, or hæmoglobin, nor on the delicate ciliary movements of epithelial cells. The foot of a curarized frog was prepared so as to show the circulation of the blood in the web under the microscope. When subjected to this magnetic force repeated observations failed to show any action upon the blood cells, or upon their movement in the blood vessels. An "idle field" magnet was next selected, and in its cylindrical cavity, measuring 2 feet by 7 inches, a dog was kept for five hours, subjected to its powerful magnet field, yet there was not the slightest visible effect upon the dog. The armature was next removed from an Edison dynamo, capable of converting seventy-horse power; this left a space between the poles of forty centimeters in diameter. Each experimenter, in turn, places his head in this space to determine, if possible, if there were any effect upon the human subject. The greatest care was taken to prevent the person being experimented upon from knowing, by sight or sound, when the current was turned on, or off. Tracings were taken simultaneously of the pulse and of the respiratory movements, and the knee-jerk was also tested. All the experimenters agreed that they experienced no sensations which could be attributed to the magnetic force, and the tracings showed no change, nor was the knee-jerk affected. The last experiment was with reversed magnetism. A large coil, 30 ctm. high, and 20 ctm. internal diameter, having 2,000 turns, was supported so that the head of the subject could be subjected to the magnetic field. It was then connected with an alternating machine, and the magnetic field reversed 280 times per second. There was absolutely no effect observed with the frequency employed, although it is possible that some particular frequency might affect the nervous system.

From these experiments the writers conclude that the human organism is in no way appreciably affected by the most powerful magnetism known to science, and that the ordinary magnets used in medicine have a purely psychical effect, and would probably be equally efficacious by way of suggestion, if made of wood.

DISCUSSION ON THE RELATIVE FŒTICIDAL VALUE OF THE GALVANIC AND FARADIC CURRENTS IN ECTOPIC GESTATION.

The participants in the discussion were requested to emphasize the following points:

1. How does electricity destroy the life of the fœtus?
2. Which current should theoretically be more certain in its results, and what is the individual experience?
3. Can electricity be depended upon to accomplish the desired end?
4. Should the galvanic current be used, interrupted or constant?
5. What is the best method of applying the agent?
6. What are its dangers, and how are they to be avoided?
7. Who should apply it? Can it be safely entrusted to the general practitioner?

Dr. Rockwell, of New York, said that in executions by electricity there was sometimes rupture of the blood vessels in the heart, owing to the tremendous force with which the organ contracts under such circumstances. Both from a theoretical and practical standpoint he preferred the galvanic current and had used it in twenty-three cases of extra-uterine pregnancy. Where the faradic current is employed it is often necessary to repeat the applications a number of times, and its use is more distressing to the patient. The extreme simplicity of the method is one of its great recommendations, and on account of this facility of application it can be and should be attempted by the general practitioner.

Dr. Malcolm McLean, of New York, was of the opinion that the life of the fœtus was destroyed by the action of the current on the extremities of the chorionic villi. He preferred the galvanic current, as purely mechanical influence was not what was most desired here. Electricity could most assuredly be depended upon for this purpose, if used at the proper time, and in the proper manner. In applying it he used an electrode placed on the abdomen over the locality of the ovum and a vaginal one consisting of a brass ball enclosed in a wet chamois bag. This electrode is placed well up in the vagina behind the uterus. One thorough application should be sufficient, but as a matter of precaution he had employed it more than once. The method seemed devoid of danger, and any practitioner who can place an electrode in its proper place, and can make the diagnosis, is fitted to treat extra-uterine pregnancy by electricity.

Dr. Goelet considered that the death of the fœtus was the result partly of muscular contraction and interference with the circulation of the chorion and partly from paralysis of the heart muscle. This explanation seemed probable on account of the effect which the contractions of the uterus at term have upon the fœtal heart. He favored the employment of the interrupted galvanic current, and in the two cases in which he had used it the results had been satisfactory. The method is thoroughly reliable. In order to properly concentrate the current on the fœtus, one pole should be placed in the vagina against the fœtal mass, and the other passed into the rectum beyond this point. The dangers of this treatment are more fancied than real; rupture is of course possible, but so far no such accident has occurred in the numerous cases reported. While the general practitioner may be qualified to carry out the necessary manipulations, he is disqualified for such work by reason of the rarity of these cases and his consequent lack of experience, and should not therefore attempt their treatment except when remote from large medical centres.

Dr. A. Brothers, of New York, said that the experiments of Dr. Lenz on small animals years ago and more recently the experiments of Martin on incubating eggs, proved that the death of the fœtus resulted from the action of the current on the chorionic villi. The galvanic current is probably the most effective, but his own case had been successfully treated with the faradic current, and in a

series of 43 cases which he collected some time ago, 21 had been treated by this current, 16 by the galvanic, 2 by both currents, 1 by static electricity, and in one the methods were not stated.

The electrical treatment is reliable, but the current should be strong, and if possible the patient should be anæsthetized. The faradic current should be employed a number of times. The interrupted galvanic current is theoretically the best form. The application is made by means of a large flat sponge on the abdomen, and the ordinary vaginal electrode. The method is free from danger, and if done in the early weeks, and before symptoms of rupture. The fact that he was himself a general practitioner was a sufficient answer to the last question.

Dr. A. F. Currier said that there were undoubtedly cases in which use of the galvanic current is indicated during the first few weeks, but its advantages under such circumstances are doubtful, for even if the subsequent history of the case be entirely favorable, one cannot be sure that the condition was really one of ectopic pregnancy. He felt that it would be exposing the patient to unnecessary danger to use an agent like electricity, which at the best is uncertain both in its immediate consequences and its ultimate results.

Dr. Gunning described some experiments which he had made on rabbits, indicating that the continuous current was safer, as it produces a vermicular action on the tube, and tended to favor the passage of the ovum along the tube. There are many more deaths, he said, following the use of the knife than after electrical treatment, and when used in the early stages of pregnancy it is one of the most serviceable and least dangerous agents at our disposal.

The President said that Dr. Gunning's experiments were an exemplification of the electro-physiological law concerning the contraction of muscle. A continuous current cannot produce a contraction of muscle by means of its nerve, but must be applied directly to the muscle, and if this be of the unstriped variety the contraction will set up a vermicular action.

Mr. Carty then referred to the probable actions of the different currents in the human body as viewed from the standpoint of the physicist.

Dr. Brothers said that one of the chief objections to the electrical treatment of ectopic gestation in the mind of Dr. Currier seemed to be founded on the assumption that something dangerous was left behind, but the speaker had taken pains to communicate with those who had reported such cases and received answers in regard to 25 of the cases, which were to the effect that in a very large number of the cases so treated there was scarcely any trace of the original trouble after periods varving from two to ten years, and in none of them was a secondary laparotomy required for the removal of any such remaining mass.

Regarding the dosage, Dr. Goelet thought 50 milliamperes would be sufficient for the constant current, if concentrated upon the mass, and 20 for the interrupted; the faradic current should be used as strong as it could be borne.

Dr. Hahn was inclined to doubt the efficiency of such a mild current, as in a case in which he had made a negative intra-uterine application with a current of 40 milliamperes in a woman who was not known at the time to be pregnant, the pregnancy continued until the seventh month and a living child was born.

Dr. Von Raitz also reported two or three similiar cases bearing upon this point, and tending to show that quite strong currents might be applied to the interior of the uterus, and yet pregnancy continue for some time afterwards.

Dr. Rockwell, in closing the discussion, said that he hoped that all would agree that the galvanic current was the best form to use. Before the general introduction of the milliamperemeter, he had employed with good results an interrupted galvanic current from 15 to 20 cells.

THE TREATMENT OF SALPINGITIS BY DEPLETION AND DRAINAGE, SECURED BY ELECTRICITY, by Dr. Augustin H. Goelet, of New York.

The author stated that he had recently reported to the New York Obstetrical Society a number of cases treated by this method, but some of the members were inclined to doubt the part played by electricity in producing good results, and objections were made to electro-therapeutics in general on the ground that it was made unnecessarily mysterious and complicated. They endeavored to explain the results by supposing that they were due to rest in bed, and the long time consumed in the treatment. In reply to such criticisms, the author said that the patients were not confined to bed at all, and the treatment was only adopted after protracted efforts by other methods, at the hands of other specialists and after laparotomy had been advised. He thought if those who believed the subject complicated would study electricity, and take the trouble to understand it, the mysticism would disappear. The principles involved in the electrical treatment were depletion and drainage, with perhaps stimulation of the lymphatics to promote absorption. The usually accepted methods of treatment he had found very slow and unsatisfactory, while electricity was not only more rapid, but often saved the patient from a mutilating operation. The essentials for success were an accurate diagnosis of the indications for treatment, and the adaptation of the electrical treatment to meet these indications. Bland Sutton says that the uterine end of the tube is rarely occluded in salpingitis, hence drainage in this direction is possible. He says further that the tender pelvic swellings are due to tumefaction and they disappear with the subsidence of the inflammation. Intra-uterine applications effect a cure of the endometritis which is usually the cause of the tubal affection, and which is directly responsible for its continuance. The faradic current is employed to relieve the pain, and to remove the capillary engorgement and tumefaction and favors evacuation of the tube by exciting peristaltic movements.

Dr. Von Raitz had treated five or six cases of salpingitis by a stronger current of electricity, preceding the application by the use of the uterine dilator.

Dr. Goelet, in closing, said he could see no necessity for preceding the application by the use of the dilator, since the negative pole produced sufficient relaxation and dilatation of the canal.

THE NEGATIVE POLE OF THE GALVANIC CURRENT AN AID TO UTERINE DEVELOPMENT, WITH CASES, by Dr. Charles G. Canaday, of Roanoke, Va.

Dr. Canaday said that in this country the brain and nervous system are usually developed at the expense of other organs, and hence imperfect development of the uterus was exceedingly common. He cited a case where the treatment advocated in the paper resulted after five months in a decided development of the uterus, and a cessation of the epileptic attacks from which the patient had suffered.

Dr. von Raitz cited a case of imperfect development of the uterus which had come to him on account of sterility. In addition to treatment directed towards improving her surroundings, a strong faradic current was employed. After about four months, conception occurred, but she aborted in a few weeks. The treatment was resumed, and at present she is in the third month of pregnancy.

Dr. Mosher, of Brooklyn, said that the infantile uterus was undoubtedly more common than is generally supposed, and that this was due to lack of attention to the physical development of the growing child. While admitting the power of electricity to develop the uterus, she wished to place herself on record as most emphatically opposed to local treatment in these young girls, especially as it

was in our power to accomplish the same purpose by attention to proper physical training of these individuals.

Dr. Goelet coincided in the views expressed by the last speaker, and added that where it was thought best to employ galvanic treatment in conjunction with the other measures, it could be done by making external applications, the negative pole being placed low down on the spine, and the positive pole at the nape of the neck.

Dr. Hall-Brown, of Brooklyn, also wished to place herself on record as objecting to local treatment except where there is some especially serious condition present.

Dr. Canaday, in closing, said that he thought all the profession were agreed concerning the inadvisability of local treatmeut in young single women, but the case of epilepsy seemed to him sufficiently serious to warrant such interference.

The President then announced the following committees:

On Static machines—Drs. Kellogg, Cleaves and Massey. By vote of the Association, Dr. Morton's name was added to the committee on static machines as chairman.

On constant current generators and controllers—Drs. Herdman, Peterson and Newman.

On electrodes—Drs. Rockwell, Nunn and Dickson.

Medical Progress.

THE IMPORTANCE OF THE AMEBA COLI IN DIAGNOSIS AND PROGNOSIS.

In an article in the *Medical News,* December 24, 1892, Dr. William T. Howard, Jr., of Baltimore, comments upon the importance of the ameba coli in diagnosis and prognosis. Attention is called to the fact that the type of dysentery characterized by the formation in the rectum and colon of ulcers and large sloughs and constantly associated with the presence of the ameba coli (the so-called tropical dysentery) is not uncommon in this country, and that it is met with in widely separated localities.

In one of his cases, in which the physical signs at the base of the right lung, together with clinical symptoms, seemed to indicate a simple empyæma communicating with a bronchus, and which was thought to be of tubercular origin, microscopic examination of the sputum showed ameba coli.

The presence of these organisms in the sputum, impaired percussion resonance at the right base posteriorly, and the fact that the patient on close questioning gave a history of previous diarrhœa, clearly warranted a diagnosis of hepato-pulmonary abscess of amebic origin.

In the writer's opinion the stools of all cases of dysentery should be examined for the ameba coli, in order to ascertain just the exact proportion the frequency which this, the ulcerative form of dysentery, bears to the catarrhal and croupous forms.

He describes the ameba coli as being round or oblong when inactive, and as of irregular outline when in motion. They have an endo- and an ecto-sarc, which are seen more clearly in active forms. The ecto-sarc is composed of a pale, homogeneous, hyaline substance; the endo-sarc is refractive and contains vacuoles of varying size. In some a more or less definite nucleus can be made out. The organisms present two varieties of motion: a progressive motion, by which they

change their place, and a motion consisting in the putting out, and the retracting of, pseudopodia, the latter being the more frequent and characteristic motion. The activity is influenced by a variety of conditions, being greatest at the body temperature. The movements are arrested by the extremes of heat and cold and by the action of various chemical substances. The pseudopodia are always round or blunt at the end, and they vary much in size. Numerous foreign bodies, such as red blood corpuscles, pus cells, nuclei of cells, and bacteria, may be seen inside ameba coli. In dysenteric stools containing ameba coli the latter are more numerous in the small gelatinous masses in the stools. Discharges suspected of containing ameba coli, whether from the bowel or from lung or liver abscesses, should be received in a covered receptacle, preferably warmed, put in a warm place and examined as soon as possible. A portion of the suspected material is examined unstained under the microscope. Often careful warming over the Bunsen flame will cause sluggishly moving or even motionless ameba to show active motility. The presence of active ameba in the discharges is to be regarded as of positive diagnostic evidence.

Attention is directed to the fact that the chronic variety of this form of dysentery is more likely to be followed by complications than the acute. The most important and fatal complication is the formation of liver abscess, the favorite seat of which is on or near the superior surface of the right lobe, and which often leads to the formation of a right-sided hepato-pulmonary abscess, which sooner or later opens into a bronchus.

Of the seventeen cases of amebic dysentery that have been reported from Baltimore, nine had liver abscesses; and of these latter there were five cases of hepato-pulmonary abscess. In these cases of hepato-pulmonary abscess of amebic origin, the prognosis is especially bad.

The use of a large aspirating needle for diagnostic purposes in such cases is justifiable. Though the pus is usually too thick and gelatinous to flow through the needle, nearly always a drop of pus will be found in the lumen of the sharp end of the needle. Microscopic examination of this pus will settle the diagnosis.

A diminution in the number of ameba present in the discharges, or their total disappearance, is usually to be taken as a good omen. The same is to be said of finding dead ameba in discharges that have previously contained only the actively moving forms.

POINTS IN TREATMENT OF ANAL FISTULA BY THE KNIFE.

Dr. Henry B. Wharton, in a recent paper before the Philadelphia County Medical Society, said:

The after-treatment of fistula-in-ano is most important, and many unfavorable results are due to carelessness in this particular. On removal of the primary dressing, at the end of two or three days, the sinus should be washed out with peroxide of hydrogen and a 1:2000 bichloride of mercury solution, and a strip of iodoform gauze should be lightly passed to the bottom of the wound and allowed to rest between its edges. The mistake is often made in packing these wounds forcibly, which interferes with healing. A piece of gauze and a pad of cotton is next applied over the wound and is held in place by a T-bandage. The patient should be kept on his back two or three weeks, and the wound should be dressed in the manner described daily or on alternate days, and at the end of three or four weeks healing is usually completed.

In cases of fistula-in-ano of the horseshoe variety, one division only of the ex-

ternal sphincter muscle should be made, and the branching sinuses should be laid open by curved incisions passing parallel with and outside of the line of the muscle. Sinuses extending to the perineum or buttock should be freely laid open.

The treatment of incomplete fistula of the external variety or of external rectal sinus consists in passing a director into the sinus down to the rectum, and if on passing the finger into the rectum, it is found that the director is separated from the finger only by the mucous membrane, and its position is low down on the rectum, it is better to push the director into the bowel and bring it out at the anus and divide the tissues as in complete fistula, and treat the resulting wound as described after the operation for complete fistula. If, on the other hand, the rectum is merely exposed at the bottom of the sinus, it is well to lay the sinus freely open to this point, curette its surface and pack it lightly with iodoform gauze. Subsequent dressings should be carefully made and the sinus will usually heal, though the course of treatment usually extends over a longer period of time than in cases where the sphincter muscle has been divided.

In internal incomplete fistula or internal rectal sinus, when the rectal perforation is low down, a bent director should be passed into the anus, and its point should be passed through the rectal opening and made to project on the skin near the anus. This is cut down upon and exposed and the director is pressed through it, making the fistula a complete one, and the tissues on the director are divided. The subsequent steps of the operation and dressing are similar to those mentioned in the cases previously described.

When the rectal opening is high up and it is considered inadvisable to divide the sphincter muscle or the bowel to its full extent, a director should be passed through the internal opening and the surgeon should cut down on its point from an incision through the skin a little outside of the sphincter muscle. When it has been exposed the sinus or cavity should be curetted and irrigated and dressed with iodoform gauze, and by careful dressing the wound the wound may be made to heal from the bottom, the rectal communication being shut off by granulation and subsequent contraction.

"IRREGULAR HEART."

An interesting discussion took place in the Medical Society of London (*British Medical Journal,* December 17th) concerning this troublesome condition, which thrusts itself so often upon the attention of the practitioner and so often baffles his efforts to control it.

Dr. A. Ernest Sansom read a paper on "irregular heart," as contrasted with the allied condition of "paroxysmal hurry." He repeated his former conclusion that the cardiac manifestations constituted the central feature of Graves's disease, the other troubles being merely offshoots. His observations did not bear on cases of arhythmia dependent upon or associated with valvular or other structural lesions of the heart, but exclusively upon long-standing cases of persistent irregularity. His cases comprised 37 in which the cardiac phenomena existed alone, and 10 of undoubted Graves's disease. He referred to the sphygmograph as a means of obtaining precise and valuable information respecting the nature and severity of the cardiac irregularity. These comprised (1) intermission; (2) the alternating pulse; (3) coupled and linked beats; and (4) external arhythmic irregularities. The etiological associations of these forms of cardiac irregularity were (1) dyspepsia; (2) syphilis; (3) osteo-arthritis; (4) disturbance of the organs of hearing and naso-pharyngeal irritations; (5) influenza; (6) mental disturbances and the

effects of severe nervous shocks; and (7) a group of cases without any of the foregoing associations, in which the symptoms were so complex as to render classification difficult. He read notes of cases belonging to each of these groups, pointing out that in only two instances did an acute disease (pleurisy) appear to have initiated the cardiac arhythmia. In only one did it appear probable that the irregularity was attributable to physical overstrain. He observed that all forms of irregular heart, whether slight or severe, were met with in cases of disturbances of the cardiac nervous system. In Graves's disease rapidity of the heart beat was more freqently met with than irregularity.

Dr. B. W. Richardson said he had given a good deal of attention to the particular variety of cardiac irregularity characterized by intermittency which might be due either to failure of the sympathetic nervous system or to over-stimulation the vagus. A point to notice in respect of this form of irregularity was that when it existed it was usually persistent, as distinct from mere irregularity. As a rule, the patient himself was not cognisant of the irregularity, and when it was perceptible to the patient it was a sign of very bad augury. Any change of this character in intermittency supervening in the course of an acute disease was usually unfavorable to the patient. In examinations for life assurance he always rejected proposals in respect of persons themselves cognisant of the irregularity.

Dr. A. Maude referred to a case of Graves's disease, in which the pulse—at first about 80—gradually increased in about a quarter of a minute to over a hundred, and then slowed again. This was not present on subsequent occasions. Living in a part of the country where goitre was common, he had been enabled to observe that, though irregularity was not a frequent symptom in Graves's disease, it was met with more frequently in persons who had previously had goitre. He referred to the observations of Tripier on the irregularity of the pulse in epileptic subjects, and mentioned a case which confirmed Tripier's opinion that such patients often died suddenly.

Dr. Woakes explained that in two of the cases referred to by the author the cardiac irregularity was associated with a special condition of the nostril; in both the middle spongy bone was cleaved, one part adhering to the septum and the other to the external wall of the nostril. He observed that cardialgia was a frequent complaint with patients applying for relief on account of disease of the nose.

Dr. Pasteur reported the case of a woman who exhibited extreme tachycardia when he first saw her. A week later this had given place to an extreme form of cardiac irregularity, the most pronounced he had ever met with. In the recumbent position her pulse at once fell to normal. Ultimately the irregularity altogether disappeared.

Dr. J. C. Thorowgood referred to the effect on a weak heart of raising the arms, and mentioned a case in which syncope had followed an effort of the kind, and the patient soon after died from heart failure. He thought this was a good test to detect heart weakness.

A DENVER DOCTOR'S TEMPTATION.

We fear that, as the centre of the universe moves west to Denver, the surgeons of that rising town, which is located somewhere near the Rocky Mountains and possesses a booming medical journal, will be subjected to great moral strains. We hope they will all resist the importunities of knowing women (for the woman of the present universal centre, Chicago, is fully acquainted with the location,

functions and procreative tendencies of the ovarian bodies) as stoutly as the editor of our esteemed exchange, the *Denver Medical Journal.*

He relates that: On one occasion a lady, who was residing with her husband at a fashionable Denver boarding house, came to my office one afternoon not long since. Almost the first question that she asked me was "Doctor, how much will you charge to take out my tubes and ovaries?" I named my customary price, which was satisfactory, and then set about making a physical examination to ascertain upon what ground the necessity of an operation might be placed. I found no pathological lesions whatever, except a slight endometritis. She was informed as to the condition present and was questioned more thoroughly, with the result that she revealed her true motives. She desired by means of the operation to forever put a stop to child-bearing, of which she thought she had already "done her share," on account of which she was in constant fear lest her "courses should stop," and to prevent which terrible calamity she had produced by means of a male catheter the endometritis heretofore mentioned. After hearing her through, I told her that I could not serve her in the capacity which she wished of me, but that doubtless there were many other excellent surgeons who would be more complaisant. Less than a month later she returned to the boarding house from the hospital where she had been spayed, perfectly contented and happy, no doubt, having buried all her sorrows with her ovaries. The surgeon who did the job is said to have found tubes, ovaries and uterus "all bound down in one mass," although strange to contemplate, "hardly an ounce of blood was lost" in the operation.

"Gentlemen and brother gynæcologists," he continues, "There can be just as much quackery in surgery as in medicine. Are we to pander to the life-destroying caprice of fashion and folly for the sake of a few hundred or thousand paltry, dirty dollars, or shall we rather rise to the dignity of our professional manhood and say 'No' with a vim and vigor that shall shatter to the dust this new and terrible Moloch?"

STRYCHNIA FOR ASTHMA.

Among the drugs recommended for use in this disease by Dr. Thomas J. Mays of Philadelphia, (*Denver Medical Times,* December 1892) is strychnia. Concerning its virtues he writes as follows:

What then is the remedy which may be given continuously for the alleviation of this disease, and without the undesirable effects of the above-named classes? Which drug will relieve asthma in stimulant doses? Such a drug, I believe, we possess in strychnine. Of course we must bear in mind that all stimulants are only supplementary agents which maintain the functions of the body without adding any direct material support to the same; but there is also good reason for believing that they cause the tissues to appropriate a larger amount of nutritive material than they would otherwise do; and in this way our stimulant drugs become tissue-builders. It has been shown that the power of strychnine in this respect is greater than that of any other stimulant. This drug has a special affinity for the nervous system, which action is especially accentuated on the pneumogastric nerves. In stimulant doses it gives a supporting influence to the respiratory movements, and unlike morphine, lobelia, belladonna or nitroglycerine, it does not depress or narcotize the nervous system. Asthma being a spasmodic disease, in what manner does strychnine bring relief? How does it act as an antispasmodic? The most probable theory of the spasmodic state is that there is at the beginning of the paroxysm a superabundant discharge of nerve force, through

the pneumogastric nerves, which throws the bronchial muscles into contraction. But whatever the intimate nature of this condition may be, it is evidence of nerve degradation or nerve weakness, and strychnine by elevating the tone of these nerves increases the controlling power of the same.

A stimulant dose of strychnine will depend upon the age of the patient, and the length of time during which the drug has been given; although asthmatics, as a rule, will bear larger doses of strychnine than other patients. Begin, as a rule, with 1-30 of a grain subcutaneously once a day, and gradually increase to 1-20 or 1-10 of a grain, or more, if necessary to impress the system with its full stimulant effects. Do not waste your time with small doses. To these amounts of strychnine small doses of from 1-400 to 1-600 of a grain of atropine may be added. It is best to administer these drugs in the evening, because asthma is nocturnal in its attacks, and your patient should be protected at night so that he may sleep.

TREATMENT OF ECZEMAS.

Writing in the *Cincinnati Lancet-Clinic* of January 7th, upon this subject, and reporting several illustrative cases, Dr. A. Ravogli, of Cincinnati, says:

In all these cases and in a great many others ichthyol has been of great benefit by local application and also by internal use. Ichthyol owes its virtues, according to Unna, to its power to diminish hyperæmia; according to H. Hebra, to the combination in it of carbon with sulphur. I ascribe its activity to its oxidizing influence, which causes the bare papillæ to be covered with cornified epidermic cells. It is also astringent, lessening hyperæmia and checking transudation of serum. Furthermore, by virtue of an analgesic action it relieves the pain and itching.

I have given pure ichthyol internally, mixed in some tea, in the dose of thirty to sixty drops a day. The patients object a little, but only at first, to its odor.

It always increases appetite, and in some cases constipates slightly. I could never discover any change in the urine, either in its color or in its chemical properties; but on boiling the urine the odor reminds one of ichthyol. There is no doubt that ichthyol taken internally has given remarkable results, helping a great deal the external application. In some cases I used either no internal medication, or only some mild purgative mineral water, and in spite of the external medication the eczema remained obstinate, but after a few days of internal use of ichthyol I could see a perceptible change in the appearance of the affected surface.

Before closnig, I must say that ichthyol did not give any satisfactory results in seborrheal eczema, which was beneficially treated by the aid of resorcin. Ichthyol can be used in any form of vehicle, as lard, vaselin, lanolin, glycerin, water, collodion, gelatin paste; and the strength, I think, must be regulated according to the case and to the endurance of the patient. The same formula which has been beneficial in one case, sometimes acts as an irritant in another. Therefore, it must be carefully regulated to the single cases.

It is my duty to mention another remedy, much like ichthoyl, found by Dr. Emil Jacobsen, of Berlin, and called thyol, which is claimed to have the same properties as ichthyol and to be much cheaper. Although Reeps, in his pamphlet on thyol and ichthyol, maintains that using them in the same patient, on one side of the body thyol and on the other side ichthyol, no difference could be perceived. Max Lange states that the difference is a remarkable one. In the clinic of Prof. Hoffmann in a large number of patients ichthyol was used on one side and thyol on the other, and it was found that the action of ichthyol was

much more successful than that of thyol. In one case the recovery was obtained with ichthyol in five days; under the use of thyol it came only after twelve days of treatment. Lange refers too, that having accidentally scalded his hand, he applied a salve of lanolin and thyol, but failed to bring any relief from the pain, which was easily relieved in a permanent way by using ichthyol in place of thyol.

In conclusion, I would say that ichthyol is a valuable acquisition in the treatment of eczema.

ALOPECIA AREATA.

Dr. L. Brocq writes thus from Paris to the *Journal Cutan. and Genito-Urinary Diseases*, January, 1893, concerning localized baldness from a therapeutic point of view: We must divide the pelades into two groups. (*a*) Those which, ordinarily circumscribed, get well easily by whatever process one employs, vesicatories, acetic acid, iodized collodion, irritating plasters, etc. (*b*) Those which are ordinarily extensive, with numerous foci, or the variety called decalvans resist all medication or recur incessantly no matter what treatment they receive. In the latter case I have remarked that the alopecia coincides at times with seborrhœa of the scalp, and it has seemed to me a useful procedure to carry out treatment for the seborrhœa, with sulphur preparations at the same time that the means are being directed against the alopecia.

BLOODY URINE.

An instructive discussion on this subject before the New York Academy of Medicine is given in the *Jour. Cutan. and Gen.-Urin. Diseases* for January, 1893. It was opened by Dr. Bolton Bangs, who reviewed the whole subject carefully, laying special stress on the cystoscopic diagnosis.

Dr. R. W. Taylor followed, referring to the urethral hæmorrhage which follows micturition in declining acute urethritis about the bulb. It may also result from compression of the urethra.

Dr. Willy Meyer referred to the value of the cystoscope in making a differential diagnosis in cases of hæmaturia. This instrument has shown that most of the old-fashioned rules which governed us in making our diagnosis were erroneous; only this one rule is still considered to be correct, that if at the end of a discharge of urine blood exudes, it comes from the bladder or the prostate. It is important to make out whether the hæmaturia is accompanied by symptoms or not; whether it is a so-called "symptomless" hæmaturia. If such a hæmaturia comes on before the age of 40 or 45, then the blood probably comes from the kidney, if abundant, or from a new growth in the bladder which is not situated near the urethral orifice. If there are symptoms, that is to say, pain, frequent micturition, etc., and we can exclude stone, then we see whether there is or is not residual urine. In a young person, if stone can be excluded, and if then there is pain and frequency of urination, there is probably an ulceration of some kind on the bladder wall. After exhausting all other methods, if we then use the irrigating cystoscope (not the ordinary cystoscope) with anæsthesia, we can in most instances expect to locate the course of the hæmorrhage. Furthermore, we must select the proper time for the examination. An inflamed and swollen *colliculus seminalis*, due to persistent masturbation in the young, may also be a source of hæmaturia. These patients first pass blood, then clear urine, and then again blood. These cases are very difficult to treat successfully.

Dr. Keyes referred to the fact that in prostatic bleeding behind the cut-off muscle a little blood will flow out after the act of urination is completed; the

next time the patient passes water he will pass a clot at the beginning of the act; then the urine will become clearer until the end, when he will again pass blood. He also referred to the resorption test advocated by Dr. Otis. If there is an excoriation of the bladder wall, and a solution of potassium iodide is injected into the bladder, the drug is quickly absorbed, and at the end of a very short time its presence can be demonstrated in the saliva by means of the starch-iodine reaction. Dr. Keyes also mentioned the fact that turpentine has proved very successful in his hands in the treatment of certain cases of renal hæmorrhage.

Dr. Morris Manges said that impacted fæces have been known to cause hæmaturia. Whether it is due to the pressure of the over-distended colon on the blood vessels or not, he did not know.

Dr. James P. Tuttle said that in a number of cases coming under his observation he has found powdered cinnamon very valuable in the treatment of hæmorrhage of the genito-urinary regions. The use of this drug for this purpose was first suggested to him by a physician in Brooklyn, and he has never seen it mentioned in any text-book on therapeutics. It acts rapidly and he has never found it to fail. One case of hæmorrhage from the kidney in which it was very efficacious afterwards proved to be due to carcinoma.

Dr. Keyes referred to the curative influence of an exploratory nephrotomy in renal hæmorrhage.

The discussion was then closed by Dr. Bangs. He mentioned the fact that a number of cases have come under his observation where tobacco seemed to have been the exciting cause in producing hæmaturia.

Medical Items.

Strips of soft filtering paper soaked in a solution of salicylic acid and worn next to the skin after drying, are recommended for sweating feet.

"Madam," said the doctor in answer to the earnest inquiry of his patient, "You are suffering from a complication of disorders, the exact nature of which can only be ascertained at the post-mortem."—*Denver Medical Journal.*

A medical exchange appears in new guise, its title-page ornamented with a full-length print of a naked woman. We regret the existence of a class of medical men whose subscriptions must be attracted in such a way.

We regret to learn from the daily press that Dr. Norman B. Scott, the oldest and one of the most prominent physicians of Washington County, was stricken with paralysis January 9th. His vocal organs were affected and he could not speak. His condition is precarious.

At its last session the legislature of Utah passed an act regulating the practice of medicine in the Territory and creating a board of medical examiners to enforce its provisions. Governer Thomas has appointed six of the seven members, giving the regular profession four members, the homœopaths and eclectics one each, and leaving one vacancy. The character of the gentlemen appointed promises the enforcing of the law and the downfall of the quack, who now flourishes profusely. Among the members of the board is Dr. Samuel L. Brick, of Ogden, a broad-minded, able physician whose high professional attainments and liberal culture will make him a leader in his new work. —*Western Medical Reporter.*

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Original Articles.

PETTENKOFER AND THE CHOLERA QUESTION.

BY JULIUS FRIEDENWALD, M. D.,
Demonstrator of Pathology, College of Physicians and Surgeons, Baltimore.

(A Letter from Berlin.)

The recent epidemic of cholera in Hamburg has excited much interest in Berlin medical circles in the various questions concerning this disease. This winter's sessions of the "Verein für Innere Medizin" have been taken up in a great measure with reading and discussing papers dealing with this subject. Dr. Paul Guttmann introduced it in an accurate and interesting account of the cases of cholera which were brought to Berlin from Hamburg and other infected parts and which were treated by him at the Moabit Hospital. Dr. S. Guttmann presented a sketch of the geographical distribution of the epidemic during the past year. Prof. Leyden demonstrated his recent studies concerning the pathological anatomy of the kidney of cholera patients.

While these discussions were in progress Germany was aroused by an address on cholera by Pettenkofer, published in the Münchener Medizinische Wochenschrift, No. 46, 1892, to which I wish to direct attention in this paper.

According to the view first published by Pettenkofer, many years ago, the appearance of infectious diseases, such as typhoid fever, has a direct connection

with the rise and fall of the soil water. Certain gases were supposed to be generated within the earth, especially when the level of the soil water was low. These gases were then liberated in the atmosphere and the disease thus became at once established in that particular locality.

After the discovery of the typhoid fever bacillus, Pettenkofer assumed that these organisms underwent certain changes in the earth under the influence of the soil water. Direct experiments were conducted by Koch and C. Fraenkel concerning this question, and they determined that bacilli were to be found only in the upper layers of the ground, and that at a depth of from two to three meters no bacilli could be discovered—that is, at depths corresponding to the level of the ground-water the soil is quite free from germs. It is probable that the constant low temperature of from 6° to 8° C., together with the lack of nourishment and the filtering process which the upper layers of the earth exert upon the lower ones, prevent the passage downward and the growth of all living organisms in, or at the level of, the soil water.†

Since the discovery of the cholera bacillus, which is a constant attendant in the fæces of all cholera patients, it is generally accepted that cholera is due to this organism alone. Pettenkofer, however, has mantained his local predisposition theory, even with regard to this disease. The etiology of cholera is regarded by him as an equation of three unknown quantities, x, y, z; x represents the cholera bacillus; y, something dependent upon locality and time (local predisposition); and z, individual predisposition. Thus, it is quite as necessary to have a predisposed locality as a predisposed individual.

Regarding the human being as the only suitable medium upon whom indisputable and incontestable experiments concerning the causation of cholera can be performed, Pettenkofer experimented upon himself. After neutralizing his gastric juice, he drank, on the 7th of October, a pure bouillon culture of cholera bacilli which had been prepared for him from cultures sent from Hamburg. During the time following this he continued to partake of his usual food. His daily observations were as follows:

October 8th, one stool, normal.
" 9th, two mushy stools; two watery stools, gurgling in the intestines.
" 10th, four very watery stools, colorless, continuous gurgling.
" 11th, two very watery stools, gurgling.
" 12th, five very watery stools; temperature 36.7° C.; pulse 86.
" 13th, four, mostly watery, colored stools.
" 14th, one normal stool.
" 15th, two quite normal stools.

From this time on Pettenkofer could not perceive anything abnormal.

On October 17th, Prof. Emmerich, after neutralizing his gastric juice, partook of a similar bouillon culture of comma bacilli. His observations were:

October 17th, one normal stool, two mushy, and one very watery stool.

†Guenther Einfuehrung in das Studium der Bacteriologie, page 134.

October 18th to 19th, three rice-water stools, each of 500 cc.; great thirst.

From October 19th, 6 A. M., to October 20th, evening, fifteen to twenty colorless, watery stools, each of 100 to 200 cc. In the evening of the 19th, 15 drops of tr. of opium were injected into the rectum, and following this, powders of opium and tannin were given.

From the night of October 19th to 20th he had eight, and from the 20th to 21st of October, twelve colorless, watery stools of from 100 to 200 cc.

On the 21st of October the first mushy stool was noticed.

From now on the stools were more consistent and on the 24th of October the stools were consistent and well formed.

In the diarrhœic stools of both Pettenkofer and Emmerich cholera bacilli were found in abundant quantities.

From these two experiments made upon the human being, Pettenkofer draws the conclusion that the comma bacillus does not produce a specific poison in the intestine, which is the cause of cholera.

Although we must look enthusiastically upon these wonderful experiments in which Pettenkofer and his colleague offered their lives in the interest of science, we must agree with Fraenkel‡ that they prove quite the reverse of what was intended. Pettenkofer points ironically to the fact that Koch and his followers claim that he and Emmerich had really passed through an attack of cholera.

If we examine the cholera cases described by Guttmann§ in which the only marked symptoms were the diarrhœic stools, we must agree with Fraenkel that both Pettenkofer and Emmerich suffered from slight forms of the cholera. From experiments made by Fraenkel, it has been shown that cultures of cholera bacilli lose part of their virulence after a time. This, together with the fact that all persons are not equally susceptible to severe attacks of cholera, may explain why Pettenkofer and Emmerich did not suffer from a severe form of the disease.

Since Pettenkofer believes he has proved that the comma bacillus cannot be looked upon as the only cause of cholera, he tries to show what other factors are concerned in the question. He points out in a series of extensive statistics that time and local predisposition of the soil are the important factors in influencing an outbreak, that dryness and a low position of the soil water were present during the summer of 1892 in Hamburg; without these the comma bacillus could not have developed. It may be remarked that the same heat, dryness and low state of soil water were general throughout Germany during this period. Why did the Hamburg epidemic not become general in Germany? An important fact has been brought out by Wallichs,‖ viz.: in certain long streets, half belonging to Hamburg and half to Altona, the epidemic was quite general on the Hamburg side,

‡C. Fraenkel, Deutsche Medizinische Wochenschrift, No. 49.

§P. Guttmann, Berliner Klinische Wochenschrift, No. 39. At a meeting of the Berlin Verein fuer Innere Medizin, December 12, Guttmann expressed the opinion that both Pettenkofer and Emmerich had passed through attacks of cholera.

‖Wallichs, Deutsche Medizinische Wochenschrift, No. 49.

whereas but few cases occurred on the Altona side. As Wallichs points out, nothing but the difference in water supply can account for this fact. Pettenkofer speaks harshly of the many regulations taken during the past year for the prevention of the spread of the comma bacillus. Inasmuch as he admits that the comma bacillus is a factor in the causation of the disease, and inasmuch as we are somewhat helpless in the regulation of the local predisposition of the soil, we cannot see why Pettenkofer objects to measures which prevent the spread of comma bacillus. Certainly the wonderful results of the regulations which have been general throughout Germany during the past half year show how by proper precautions the spread of this dreadful disease may at least in part be prevented.

A SUGGESTION FOR THE PREVENTION OF THE VERY BAD ARM THAT OFTEN FOLLOWS VACCINATION WITH BOVINE VIRUS.

BY WILLIAM T. CATHELL, M. D., OF BALTIMORE.

The alarming and long continued sore arm, that in primary vaccination so often follows the use of bovine virus, may be prevented by carefully instructing those in charge of the patient to try daily to raise the scab, after about the 21st day, and to remove it as soon thereafter as it is found to be detachable; next to mop and wipe the sore until dry, and then to let the air glaze its exposed surface before reapplying the clothes; and also in case the edges are loose, but the crust is still held on by the strong and fleshy core that so often exists at its centre, to first go around the scab with the finger nail and separate the edges, and then cut off with scissors all this loosened margin, and also to cut away as much as possible of the central core itself, either then or whenever it becomes sufficiently dead and insensitive, after which the sore may either be dressed with a salve or dusted with aristol, iodoform or europhen, if its condition is required.

This not only prevents the excessively sore arm and chronic ulcer with its burrowing, corroding and tissue-absorbing pus, with the huge and unsightly keloidal cicatrix, but also secures the characteristic scar with its series of minute depressions or pits, which unmistakably prove that it is the relic of a genuine Jennerian vesicle.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD DECEMBER 2, 1892.

The 472nd regular meeting was called to order by the Vice-president, Dr. J. M. Hundley.

Dr. J. E. Michael read a paper entitled SYMPHYSIOTOMY; A SUCCESSFUL CASE; A SUGGESTION. The ancient history of the operation was briefly referred to. Dr. Harris' paper, read before the last meeting of the American Gynæcological Society and published in the *American Journal of Obstetrics* in October, 1892, leaves little to be said as to the modern history of the operation. Dr. Harris' table,

showing forty-four operations from January, 1886, to July, 1892, by various operators, with one maternal death, three still-born children dying respectively at 12 and 72 hours, made a profound impression on the American profession. Dr. Charles Jewett, of Brooklyn, was the first American operator. He operated on September 30, 1892. The child died in twenty-four hours from the effect of long continued pressure. The recovery of the mother was uneventful. Professor Hirst, of Philadelphia, operated on October 2, 1892. Child and mother both well. Professor Broomall operated October 7, 1892. Mother and child saved. Dr. Michael operated at the Free Lying-in Hospital of the University of Maryland, October 24, 1892. The patient was a rachitic negress four feet six inches high and seventeen years old. Labor began on the morning of the 23rd. Dr. Michael saw the patient at 9 P. M. Os barely admitted two fingers. Head large and no sign of engagement. Fœtal and maternal circulation good and general condition of patient satisfactory. It was concluded to wait for greater dilatation, and operation was postponed till morning. Operation at 9.30 A. M., chloroform anæsthesia. Os still small; most of the amniotic fluid had escaped and the fœtus was suffering from pressure. Fœtal head obviously large and no possibility of engagement. The bladder was evacuated and then the os uteri dilated until four fingers would enter. The soft tissues were incised down to the symphysis and the attachments of the recti were separated for half an inch on each side. The finger was passed down behind the symphysis until it projected below. The soft parts from the outside below were incised down to the finger tips. An ordinary curbed probe-pointed bistoury was passed behind the joint, and the cartilage severed. Delivery by Simpson's modification of Tarnier's forceps. Pubic separation at its highest point was 2¾ inches. Notwithstanding all precautions the cervix was lacerated into the vaginal vault, the perineum to the verge of the anus and the anterior vaginal wall into the operation wound. The lacerations repaired at once with catgut. The wound of the symphysis was sewed with gut, the deeper stitches including the pubic ligaments. The surface was powdered with aristol and dressed with iodoform gauze. Broad adhesive strips encircled the pelvis and were covered by a firmly applied bandage. The puerperium was uneventful. On the ninth day the patient was allowed to sit up in bed; on the eleventh day sat up a little while in a chair; on the twelfth day could walk well and firmly.

At the present time she walks all over the hospital as firmly as before the operation. The child died on the third day, the death being due to pressure which had occurred previously to the delivery. Dr. Michael, since the operation, has procurred a Galbiati knife which he believed would have been of great service in the operation.

Dr. Michael believes that symphysiotomy will not only to a large extent take the place of Cæsarean section and of craniotomy on the living child, in cases of contracted pelves, but will be of service in the delivery of living children in cases of bad presentation where formerly craniotomy has been resorted to. He has examined this matter experimentally with a fœtus of large size and a pelvis with the soft parts attached, of comparatively small size. Placing the fœtal head into the pelvis and producing a posterior rotation of the chin delivery was attempted by forceps, but was found to be utterly impossible. Symphysiotomy was performed and after the pubic bones were separated 1½ inches, the head was easily flexed upon the trunk, the occiput brought under the pubic arch and delivery by extension occurred in the usual way. Dr. Michael was so impressed with the feasibility of this operation that he intends to perform it on the first

case of malposition of the head that presents itself to him. In cases where the occiput is posterior and the delivery of the child with forceps is accompanied with a great amount of violence, he thinks that this operation may be indicated. The number of operations which have been performed the present year the world over, as collected by Dr. Harris, of Philadelphia, is 26. In this list there is no death of the mother. The statistics are remarkable both as to the safety of the woman and the healing of the wound.

Dr. Hunter Robb asked Dr. Michael if in his case he has been able to suture the pubic ligaments as described by Leopold, of Dresden, in a case of symphysiotomy.

Dr. Michael said that the ligaments of the pubes offered a very considerable amount of tissue which might be caught with sutures. It would be unwise to depend upon sutures, however they were passed. The pressure from the sides as produced by adhesive plasters and a well-applied bandage over them is so complete that you get a support which no suture of any kind could supply and it would not make a very great amount of difference if the ligatures were not applied at all.

Dr. Robb congratulated Dr. Michael upon the success of this case. He thought that symphysiotomy would undoubtedly have a prominent position in obstetric surgery. On account of the simplicity of the operation, there will be great danger of its being performed more often than is necessary.

The pelvic measurements should be made as carefully as possible, with consultants of sufficient experience, before operation, just as is done when the Cæsarian section is thought of. In some cases the operation is undoubtedly so clearly indicated that immediate action is justifiable, but these cases he believed, form the large minority. Symphysiotomy does not provide for as many abnormal conditions as Cæsarean section; for example, where one has to deal with cancerous growths of the cervix, pelvic exostosis, tumors of the uterus, and some deformities of the pelvic bones, it would be useless to do symphysiotomy.

He believed, however, that the operation would perhaps save the lives of many children; on the other hand, it may leave undesirable results in the mother.

Dr. William S. Gardner said that the profession was indebted to Dr. Michael for bringing this subject before them. This operation will almost entirely take the place of craniotomy on the child where the condition is that of contracted pelvis. Of course nobody would dream of doing symphysiotomy for a cancerous cervix or where the obstruction was due to any other condition in the pelvis than that of contraction. The operation will also cut in very largely upon the Cæsarean sections, especially those Cæsarean sections done in the United States. The fact is very well known that we have in the United States a very small number of extremely contracted pelves and that a large percentage of the Cæsarean sections that have been done were upon women who had only what is known as the "relative indication." With reference to the suturing of the pubic bones, Leopold remarked at the time he was stitching the wounds that he did not consider the stitching of very much value and that he placed his main reliance upon the external bandage. The bandage which he used was made of heavy ducking, and was fastened by a buckle resembling an ordinary suspender buckle. The hips were padded with towels and this bandage was drawn over them very tightly; in fact, so tightly that it produced sores on both the crests of the ilium in his first case. In Germany, and in most of the European countries, they have a large number of cases where the degree of contraction is so extreme that sym-

physiotomy is not a practical operation. The Galbiati knife is probably of great convenience to the operator.

Dr. Norment was particularly interested in the suggestion which Dr. Michael made as to the performance of symphysiotomy to save the necessity of craniotomy upon the living child on account of malposition of the fœtus. He had once been compelled to do craniotomy in a face presentation, chin posterior. He saw very readily wherein the operation of symphysiotomy would give relief to that condition. It is an operation which is not to be attempted by any and every one. As Dr. Robb has said, it should not be resorted to till after the judgment of able consultation had been passed upon it. The necessity of getting consultation or of getting some one else to do the operation would take away from it a great part of its service, because often in private practice the delay necessary to secure these things would be dangerous to the mother.

Dr. Branham thanked Dr. Michael for bringing up the subject. He thought that the operation was still on trial and that it would not be best to jump to the conclusion, as is so often done when these operations are revived or first brought out, that it is to be a continued success. The statistics on the subject as presented are extremely favorable to the operation, and it seems undoubtedly that the very recent operations have been quite successful, but even since the introduction of antiseptic methods the operations done between the years 1880 and 1886 and collected by Morrisini, give a mortality of 8 in 18 operations. Of course the mortality seems to have been reduced almost to nothing, but I am inclined to think that more than likely the favorable cases have been reported and the unfavorable cases have not. It hardly seems probable that an operation could be so much improved since 1886. A good many cases which have gotten well have been followed by chronic disease of the bones about the pelvis. The probabilities are that better antiseptic precautions have diminished the frequency of this sequel. It is more than probable that there will be a certain number of cases in which more or less permanent injury will result. The operation will doubtless have a future to it, still, we should not conclude, until these cases have been done for a long time, and the final results as to the condition of the pelvic bones are known, that this operation is going to take the place of Cæsarean section. As far as operation in cases of impaction is concerned, if it can be done in time to save the child, it is a very good thing and will doubtless be carried out in a great many cases.

Dr. Michael: Of course the operation of symphysiotomy in case of tumor and cancer and that sort of thing is not to be thought of. It only applies to such conditions as can be changed by the effect upon the bones. The discussion of the question of symphysiotomy in a case of malposition can only come up when the head is down and impacted. With a child dead and posterior chin, or a child nearly dead, of course symphysiotomy is not to be thought of; but with a jammed head and a living child where the alternative rests between craniotomy and symphysiotomy the latter is to be elected. Dr. Branham's position in regard to conservatism is a proper one. We should always receive new operations with a certain amount of skepticism and it is very well to look closely into the results of operations before jumping to conclusions. What he says in regard to operations reported between 1880 and 1886 is perfectly correct, but if he will look over hernia or any other class of operations in which much tissue is involved or cavities of importance invaded, which were made within the same period, he will find that the mortality was greater than it is to-day. Even the operation of Cæsarian section has improved wonderfully since the period mentioned. As to

the matter of reporting favorable cases, we certainly have a complete record of the work of men who are prominent in these branches and in whom the suppression of unsuccessful cases would be simply disgraceful. I am firmly convinced from Dr. Harris' figures that there is an amount of improvement in the results of symphysiotomy due to antisepsis that is represented by the reported cases. Of course there must be concealed cases which were unsuccessful, as there may be concealed cases of any operation of gravity, but the reports we have here are fully as reliable as reports of any subject of this sort. We have not here an operation which is on trial. When we can present a record of fifty-two cases it strikes me that the utility of the operation for saving life has been demonstrated. If we do not accept this number of cases as proving it then I do not see how we are ever going to prove it. We should not hinder the wheels of progress by referring to the bad work of ignorant people. I think the utility of the operation is demonstrated.

Dr. Hunter Robb read a paper on HYSTEROMYOMECTOMY FOR LARGE MYOMATA OF THE UTERUS. Dr. Robb strongly advocated the intra-peritoneal method of treating the pedicle after the removal of a myoma of the uterus. The dangers of sepsis and hæmorrhage with improved technique are less than when the extra-peritoneal method is employed, and are not much greater than in an ordinary ovariotomy. The various devices for controlling hæmorrhage were considered. The danger from sepsis from the cervical canal can most surely be obviated by curetting both the uterine and cervical mucosa several days prior to the removal of the tumor. At the same time the cavity of the uterus can be cauterized gently with the small point of a Paquelin cautery and a strip of 10 per cent. iodoform gauze packed in, to be removed the day before the operation. The vagina can be made sterile by irrigation twice daily for two or three days prior to the operation with $\frac{1}{3}$ per cent. warm solution of carbolic acid. The vagina between douches should be packed with iodoform gauze. The external genitals should be rendered aseptic. After removal of the tumor the cervical canal should be sterilized by plunging the Paquelin cautery well into the lumen of the canal. The results obtained by this method in the Johns Hopkins Hospital within the past year and a half have been more satisfactory than where other methods were employed. The period of convalescence is shortened and there is not nearly so much danger of the hernial complications that are apt to follow other methods. Dr. Robb now drops the pedicle in every case of hysteromyomectomy. The paper was illustrated by large bromide prints showing the different steps taken in the operation described.

Dr. W. P. Chunn thought that a method which had not been mentioned by Dr. Robb—namely, where no pedicle was left at all, was a particularly good variety and one which would some time come into a great deal of use. He believed that wherever it was possible to get rid of the extra-peritoneal method it should be done, for with the greatest care we are apt to have some sepsis. In cases where hæmorrhage is feared we advise that an extra suture be passed through the stump and be allowed to come out at the lower end of the abdominal wound, so that it can be gotten at more readily if hæmorrhage occurs.

Dr. W. S. Gardner described a method of dealing with the stump by covering it with flaps of peritoneum. He advised cutting out a rim of tissue around the cervical canal after the use of the Paquelin cautery, so as to get fresh surfaces instead of the cauterized. Where there is a considerable mass of tissue in the stump, it is difficult to tie it tight enough with ligatures to control hæmorrhage. The uterine tissue, under pressure, will decrease in size and the ligatures become

loose. A useful measure to prevent hæmorrhage is to pass a stitch around each uterine artery.

Dr. Robb: In my paper I have only considered whether we should drop or in some way fix the pedicle, and I have endeavored to show that with our improved technique we are able to drop the pedicle and not treat it by any form of fixation in the abnormal wound. The entire removal of the uterus practically leaves no pedicle, and therefore I have not mentioned this method nor the method of vaginal fixation described by Dr. Byford, of Chicago.

The point of greatest interest to abdominal surgeons is whether the pedicle is to be treated extra-peritoneally or intra-peritoneally. The dropping of the pedicle is the ideal procedure and does much to simplify the operation. I think is generally conceded that our technique must be such that this method can be employed.

The uterine arteries can be ligatured in some cases in the way which Dr. Gardner mentions.

Dr. Edwin K. Ballard exhibited A LARGE UTERINE FIBROID REMOVED BY SAW-SPOON. The patient, Miss B., aged 53 years, entered the Hospital for Women of Maryland, suffering from a sub-mucous fibroid about the size of a fœtal head. Ergot was given for a number of weeks and the os dilated under this treatment to the size of a silver dollar. The patient had formerly suffered from profuse hæmorrhages and was weak and anæmic. On November 29th, Dr. H. P. C. Wilson, assisted by Drs. R. T. Wilson, E. K. Ballard and W. McL. Yost, operated for the removal of the growth. The pedicle was broad, sessile and attached mainly to the fundus and posterior wall of the uterus. It was found utterly impossible to use the ecraseur. The Thomas saw-spoon was passed full length of the shank, eight inches, but failed to reach the base of the tumor.

Nothing remained but to cut away portions of the protruding mass and remove it piece-meal. Accordingly an attack was made on the main body of the growth from which a piece was sawed loose, pulled out and cut off with the saw-scissors. The next presenting portion was seized by vulsella, dragged down and detached in a similar manner. After a number of sections had been thus removed, the remaining pedicle was drawn down into view and acted upon by the saw-scoop, with which it was, after much difficulty on account of its density, cut away. By this time the patient had lost a very large quantity of blood and was profoundly collapsed, but by vigorous stimulation with amyl-nitrite by inhalation, together with whisky and digitalis hypodermically, she was somewhat revived. Cervix and perineum were both torn during the operation. After removal of the growth the uterus was flushed with hot water and mopped with a mixture of Monsel's solution, carbolic acid and glycerine as an antiseptic and styptic. The patient was carefully put to bed and stimulation continued. She promptly rallied and has progressed favorably.

1519 N. Broadway. W. T. WATSON, M. D., Secretary.

TRANSACTIONS OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

SECOND ANNUAL MEETING, HELD IN NEW YORK, OCTOBER 4, 5 AND 6, 1892.

SECOND DAY, OCTOBER 5, EVENING SESSION.

The following officers were elected: President, Dr. A. H. Goelet, of New York; First Vice-President, Dr. W. F. Hutchinson, of Providence; Second Vice-Presi-

dent, Dr. W. J. Herdman, of Ann Arbor; Secretary, Dr. Margaret A. Cleaves, of New York; Treasurer, Dr. R. J. Nunn, of Savannah.

The Association decided to hold its next meeting in Philadelphia on Tuesday, Wednesday and Thursday immediately following the session of the Pan-American Congress, September 12, 13 and 14, 1893. After the adjournment of the executive session, by invitation of the resident members of the city of New York, the members of the Association, their ladies and invited guests were entertained with a private lecture and exhibition of the phonograph and micro-phonograph. The lecturer, Dr. J. Mount Bleyer, described the circumstances leading to the invention of the phonograph and the general principles of its action. He then took up the micro-phonograph, and showed in what respects it differed from the ordinary phonograph. Lieutenant G. Bettini, the inventor of the micro-phonograph, found that the diaphragm, instead of vibrating as a whole, vibrated in numerous small divisions or sectors, which may happen to be in tensioned sympathy with the vibrating organs of the voice, or of other tones directed against the diaphragm. In order better to utilize these vibrations, instead of having the central needle-point connected rigidly with the diaphragm, he attached it by means of a number of radical bearings of unequal length, so that should the centre of the diaphragm, for example, happen to be a node or a silent point not in sympathy with a certain pitch or tone, some small sector might prove to be in exact sympathy, and would thus cause the needle through one of these bearings, or "spider legs," to respond, and in this way the whole diaphragm would not only be utilized and the tones made many times louder by a single point, but the instrument would be capable of reproducing a much greater variety of *timbre* of the voice, and a much greater number of voices and sounds than it would be possible to do with the ordinary phonograph.

This principle, which the inventor worked mechanically, was also developed about the same time theoretically by Dr. Wilford Hall and described by him in an editorial in "The Microcosm," Vol. IX, February, 1892. A more remarkable case of determining intricate mechanical and scientific results by pure philosophical reasoning, it would be hard to find. Dr. Hall denies that a sounding instrument sends off any *air* waves at all, and claims that *sound* waves radiate from a sounding body. This sound force is assumed only to act sympathetically on a body in union with its vibrational number, and it is a fact that tensioned diaphragm is really composed of many sections of tensional sympathy, each one of which is actuated by a tone of corresponding pitch of synchronism. It is evident from this that such sectional vibrations of a diaphragm of a phonograph at all sides of the needle, according as the pitch and intensity of the tone change, must give a slight lateral movement to the needle point in its line of indentations on the cylinder, as well as the appropriate varying degree of depth and distance apart of the individual impressions. This, then, is the secret of the wonderful powers of the phonograph.

Dr. Bleyer then described the various applications of the phonograph, particularly in medicine. At the close of the lecture, Lieutenant Bettini gave an exceedingly entertaining and successful demonstration of the remarkable powers of his micro-phonograph.

The guests then adjourned to the banquet room and participated in a collation which had been provided for them by the resident fellows.

Professor Hare recommends aconite as the best of all drugs for pulmonary hæmorrhage.—*Ex.*

TRANSACTIONS OF THE MEDICAL SOCIETY OF WASHINGTON COUNTY.

MEETING AT HAGERSTOWN, MD., NOVEMBER 9TH, 1892.

The last stated meeting for the year 1892, of the Medical Society of Washington County, Md., was held in Hagerstown on November 9th.

MORNING SESSION.

After the ordinary routine business, Dr. J. W. Humrichouse, of the committee on medical and surgical communications, reported that papers had been secured during the current year from Dr. J. Edwin Michael, of the University of Maryland; Dr. W. C. Wheeler, of Boonsboro; Dr. D. C. R. Miller, of Mason & Dixon, Pa.; and Dr. Randolph Winslow, of the University of Maryland. The committee closed its report with the hope that the Society would not let its interest in the reading of papers flag, as it was only by such work that the true function of the Society was manifested.

Dr. J. McP. Scott called attention to certain violations of the State medical law. He informed the Society that the Board of Medical Examiners of Maryland had held its first meeting in Baltimore in October, in accordance with the provisions of the law, and that although the Board had been notified that the names of 160 or 170 persons desiring to practise in the State had been registered, not a single applicant had appeared before the Board for examination. Dr. Scott said further that it was evident that the law was either ignored or defied, and that it was deemed advisable to arrange some programme by which the Board be given authority to act in the matter.

Dr. Scott also presented for signatures a petition from the Pan-American Medical Congress to the Senate and House of Representatives of the United States, having for its object the securing of an appropriation of money to assist in defraying the expenses of the Pan-American Medical Congress to be held in Washington, D. C., in September, 1893. The consideration of the petition was laid over until next meeting.

Dr. Elmer C. Kefauver, of Mechanicstown, was elected a member.

The election of officers for the following year was as follows:

President, Dr. A. S. Mason; Vice-presidents, Dr. A. G. Lovell and Dr. J. McP. Scott; Recording Secretary, Dr. H. U. Onderdonk; Treasurer, Dr. E. M. Schindel; Corresponding Secretary, Dr. J. W. Humrichouse.

Dr. Humrichouse offered a resolution to the effect that the Society request the municipal authorities of Hagerstown to give their co-operation and support to the Health Officer of the County in carrying out needed sanitary regulations and to pass an ordinance giving the Health Officer certain powers in cases of contagious and infectious diseases.

After considerable discussion the resolution was amended and laid over for final action until the next meeting.

AFTERNOON SESSION.

At the afternoon session Dr. E. Tracy Bishop, the President for the year 1892, yielded the chair to the new President.

Dr. A. S. Mason, after referring to the present high status of the Society and the good it had done in the past, then suggested some things that the Society should give its attention to in the future, among which was action looking to the establishment of a hospital for important surgical cases and for the treatment of the insane.

Dr. Mason, in assuming the chair, expressed in a few happily chosen words his appreciation of the honor conferred upon him.

Dr. D. C. R. Miller, of Mason & Dixon, Pa., read a paper entitled FOREIGN BODIES IN THE WINDPIPE, giving reports of two cases. The first case was that of a child aged two years and eleven months, who had got a portion of peanut shell in the trachea, causing at first violent spells of paroxysmal coughing, which after a time subsided. In a short while symptoms of pneumonia in the right lung set in. The pneumonia subsided after treatment. Two months after the accident the child was taken with a violent attack of coughing and the peanut shell was expelled.

In the second case a child aged two years and six months had a head of timothy in the right bronchus for three months. At first there was great distress, which soon subsided. In a short time symptoms of tuberculosis developed, but on treatment the health of the child improved, and at last the foreign body was thrown off in a paroxysm of coughing in a disintegrated condition.

Dr. Humrichouse then read some statistics showing the comparative results of interference and non-interference in such cases as Dr. Miller had reported, and stated that the good and bad results were so equally balanced that the figures did not show that much was to be gained by an operation. He also gave some cases of his own showing the importance of a laryngoscopic examination.

Dr. N. B. Scott cited two cases in his own practice, in which, as in Dr. Miller's cases, the foreign bodies had been expelled spontaneously after remaining a considerable time.

In answer to a question as to how long it would be safe to allow a foreign body to remain in the trachea, Dr. Miller said that he would be unwilling to allow the body to remain after determining its presence, but would operate at once.

Dr. N. B. Scott was of the opinion that the indications should be met as they arose, and advocated a conservative treatment.

Dr. Humrichouse said that in the acute condition of emergency, the introduction of the O'Dwyer tube gave the quickest relief. In the chronic condition, bronchotomy was dangerous and did not promise good results.

After further discussion by several members, the President stated that the inference was to let those cases alone where they are giving no trouble, and to operate when there is distress and danger of suffocation.

The topic for general discussion for the day, "The Treatment of Tetanus," being announced,

Dr. T. W. Simmons introduced the subject by some remarks upon the prevention of tetanus, in which he presented a new and original treatment. After outlining the germ theory of the disease, and describing the bacillus of tetanus, Dr. Simmons stated that the disease was caused by ptomaines produced by the bacilli, and that the bacilli did not leave the wound, but that their poisonous products were absorbed into the system, giving rise to effects analogous to those of strychnia. It was maintained by Dr. Simmons, that as experience had shown how little was to be expected from a treatment looking to the cure of the disease after the symptoms had set in, it was the duty of the physician to kill the germ in situ, and thus prevent the formation of the poisonous products. To effect this, Dr. Simmons stated that he injected into the lumen of the wound a solution of cocaine, and after a few minutes withdrew from the wound whatever cocaine remained. He followed this, by means of the same instrument used for the injection, by an injection into the wound of the following solution:

℞.—Hydrarg. bichlorid. . . grs. ij.
Acid carbolic. . . . grs. xv.
Alcohol . . . . ℥ ss.

Dr. Simmons exhibited an instrument devised by himself for making these injections.

Dr. Waddy asked how often the injections were necessary.

Dr. Simmons answered that one injection might be sufficient.

Dr. J. McP. Scott, while expressing great respect for the bacteriologists, was not prepared to accept the germ theory of tetanus as proved; but, even admitting the presence of bacilli in the wound, he failed to see what advantage Dr. Simmon's method had over other means—for example, the actual cautery, if the sole object of the treatment was the destruction of the bacilli. Dr. Scott favored laying open the wound by a free incision and poulticing to induce suppuration.

Dr. Reichard also took the ground that the verdict at present as to the germ theory of tetanus must be "not proven."

Dr. Simmons mentioned that animals inoculated with cultures of the specific bacteria of tetanus had died with all the symptoms of the disease.

Dr. Reichard objected that the animals so inoculated did not show the symptoms of true tetanus as exhibited in the human being; inasmuch as the convulsive disturbances invariably began at the seat of puncture and extended from that point. Tetanus in man never developed in that way.

The President stated that he did not see how the theory that tetanus was caused by specific bacilli entering a wound could account for cases of idiopathic tetanus.

Dr. Humrichouse expressed his reluctance to admit the existence of idiopathic tetanus.

After further discussion of Dr. Simmon's treatment by Drs. Bishop, Herman, Humrichouse and the President, the meeting adjourned.

After the meeting the following were announced as the standing committee for the ensuing year.

Finance: Dr. E. M. Schindel, Dr. W. C. Wheeler, Dr. D. C. R. Miller.

Ethics: Dr. J. McP. Scott, Dr. A. Shank, Dr. W. M. Nihiser.

Publication: Dr. H. U. Onderdonk, Dr.C. R. Scheller, Dr. H. K. Derr.

Medical and Surgical Communications: Dr. J. W. Humrichouse, Dr. C. L. G. Anderson, Dr. V. M. Reichard.

Council of Appeal: Dr. T. W. Simmons, Dr. E. Tracy Bishop, Dr. N. B. Scott.

H. U. Onderdonk, M. D., Recording Secretary.

It is well known that in the malarious Pontine marshes, in order to avoid breathing the air which is in close contact with the soil, and to reach the higher stratum of atmosphere which is free from the poison of malaria, platforms four or five metres high are erected, upon which the people sleep in the open air with comparative impunity. In Greece, the jungles of the East Indies, and Central and Southern America, similar devices are said to have been adopted with beneficial results.

Another mode of eluding the malaria-laden air in close contact with the ground is to construct the dwellings in such a way that when the door is shut the internal atmosphere is renewed only by the strata of the local atmosphere which are near the roofs of the houses. This is managed in some localities by so arranging that the only opening in the outer walls is the door, and all the windows open on an inner yard on a higher level than the ground floor of the house.

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BALTIMORE, JANUARY 21, 1893.

Editorial.

THE TARIFF ON MICROSCOPES.

Replying to an article in the New York *Medical Record,* which maintains that the members of the medical profession should refrain from opposition to the above tariff because of their obligations to manufacturers of apparatus and instruments, the *Cincinnati Lancet-Clinic,* of January 7th, expresses itself in part as follows:

"Microscopes of foreign manufacture are taxed forty per cent. when sent into this country. This tax, of course, is paid by the one who purchases the instrument, and it is a fact that American microscopes are kept at a figure which is much higher than it would be were it not for the tariff. Why should we be compelled to pay forty per cent. more than the instrument is worth? The last sentence of the extract is a remarkable one, in that it implies that we are under obligations to the firms supplying us at present. Under what possible obligation are we to them? The obligation is all the other way. They have been paid well for all we have ever gotten from them. Can there be any obligation to those who received full, nay excessive, compensation for all we purchase? We rather think they are obliged to us for our patience and long-suffering under imposition. We are heartily sick of such expressions as the one quoted. All we ask is the opportunity of buying where we can put our money to the best use. It is not a question of favor or obligation, it is a pure business proposition.

"In conclusion, we feel that the medical profession should speak emphatically and clearly upon this subject by urging and demanding the removal of the tariff from such articles as add to their efficiency as scientific men. They should aim to promote the freest and fullest possible exchange of scientific ideas and appliances. The onward march of science should not be fettered by artificial restraints."

It *does* seem to us, of Maryland, a little absurd that so much trouble should

be taken in the medical colleges exempted from tariff duties to train students in the diagnostic uses of an instrument which most of them will not for years have the money to buy. Certainly the high power appliances for the proper diagnosis and study of disease-germs are utterly beyond the purchasing powers of the average medical practitioner, who, with the present high prices, looks upon the immersion lens and its accompaniments as a luxury to be indulged in only by wealthy pathological institutions which import them duty-free for teaching purposes.

Perhaps the tariff on microscopes is a beneficent institution tending to prevent the great mass of medical men from joining in the extremes of germ-diagnosis and germ-therapeusis; and driving them back to ordinary clinical observation by their unaided senses. If so, it should not be removed. Yet we *would* like the graduate in medicine to buy a microscope at the beginning of his career, if only for the study of skin-growths of vegetable origin and for the diagnosis of kidney diseases. A man with a gonorrhœa generally has an inward consciousness that he has been near an infected watercloset, so we don't need the microscope very much for him.

It is very doubtful whether the microscopic diagnosis of tuberculosis will ever be of much value to the mass of practitioners as long as microscope lenses, especially those of great power which are necessary for accurate diagnosis, are subject to the high prices maintained through the influence of tariffs.

It really seems as if it were about time for some of our "infant industries" to make some effort to wean themselves and to learn to walk. We fear that they will become so fat and indolent that they will never find their legs.

REPRINT RIGHTS.

We have been called to account for quoting in a recent editorial from an article by Dr. Mattison on "Codeine in the Cure of the Morphine Habit," without crediting the *American Therapist,* in which it originally appeared. The editor calls our attention to the fact that the *Therapist* is copyrighted and pays for its articles, and desires that we will make a note of the caveat filed.

In reply we would state that we never intentionally use material of importance from other journals without due credit, and are glad to be politely reminded of any such apparently discourteous action. We believe that this is the rule with all respectable journals, whether the matter is originally paid for or not. In the present case we became absorbed in the clinical interest of the article, which reached us in reprint form only, and were not impressed with the thought of its origin, as we are not familiar with either the name or appearance of the *American Therapist.*

As there is no notice printed on the reprint to the effect that the article was copyrighted or that it was paid for, we can hardly be held accountable on these points.

If the *American Therapist* has copyrighted its reprints, it ought to state the fact upon the cover of the reprint. If it has not copyrighted them, it should not pretend to claim any privileges concerning them not claimed by uncopyrighted journals.

Reviews, Books and Pamphlets.

A Text-Book of Ophthalmology; by ERNEST FUCHS, Professor of Ophthalmology in the University of Vienna; authorized translation from the second enlarged and improved German edition, by A. Duane, M. D., Assistant Surgeon, Ophthalmic and Aural Institute, New York. with numerous illustrations. New York: D. Appleton & Co., 1892. Octavo.

An oculist of this city, to whom we referred this volume for review, considered it the best text-book upon the subject in the English language. He writes us as follows:

Messrs. Appleton & Co. have issued in their best style an excellent text-book of opthalmology, written by Dr. Ernest Fuchs, of the University of Vienna, and well translated by Dr. Duane, of New York. When each has performed his task so well, there can be nothing but praise. We believe the specialist will find in it all that is best, as well as latest, in his branch; the general practitioner, just what he needs to scatter the mists of the past; and the medical student, one of the best and most comprehensive ophthalmological text-books in the English language. The translation runs smoothly and easily into good English. The illustrations are numerous and excellent; many are new and are all well chosen. After an experience of twenty-five years in this branch of medicine we do not remember welcoming a more acceptable addition to our library.

The Medical and Dental Register-Directory and Intelligencer of Pennsylvania, New Jersey, and Delaware; GEORGE KEIL, editor. Octavo, 424 pages, cloth. 1892: George Keil, 306-308 Chestnut Street, Philadelphia.

This book contains the medical and dental laws of the above States, complete; a list of the medical and dental colleges of the United States, with names of faculty in each; the names and addresses of officers and place of meeting of the national, State and county medical and dental societies of every sect; and the names and addresses of all physicians and dentists in Pennsylvania, New Jersey, and Delaware. The publisher's work is good throughout. Lists of asylums, homes, dispensaries and hospitals in the three States are included.

Medical Progress.

CHOLERA PRECAUTIONS IN NEW YORK.

As reported in the Baltimore *Sun*, Senator Chandler gives the following account of the results of the tour of inspection made early in this month by the United States Senate Committee on Epidemic Diseases:

The preparations for isolating cholera cases if the disease should succeed in passing the State and national quarantine defences and get into the city, are first, a reception hospital at the foot of Sixteenth Street, on East River, where a large new hospital is to be built this winter to accommodate one hundred people. That and the Willard Parker Hospital, now on the same spot, will ordinarily be

used as the Parker Hospital is now used—for diphtheria, scarlet fever and other contagious diseases, but in an emergency all these will be treated elsewhere and the buildings will be the first place to which patients stricken with cholera in the city will be taken.

Then we went down the bay and examined the hospital at North Brothers Island, where, in addition to the main buildings, were twelve large wooden pavilions (and more are to be erected) where the typhus fever patients are now treated. These would be used for the reception of cholera patients if they could not all be treated upon the floating cholera hospital owned by the State Board of Health, but the Board hopes to be able to get along without placing any cases on the land. The Board of Health has also Ricker's Island, near North Brothers Island, which insures ample accommodations for all probable or possible patients. At the latter place tents could be used, a method of treatment which is in high favor among the medical men. The tents are easily warmed in the cold weather and the purity of the air, the easy disinfection and other points, recommend themselves.

In addition to the State and city preparations, there was Camp Low, established by Dr. Hamilton at Sandy Hook. This is composed of wooden barracks, but with heating and electric plants and a hospital separated from the barracks. In them 2,000 people could easily be kept in quarantine without discomfort. It might be stated at this point that in connection with the Hoffman and Swinburne Island stations Dr. Jenkins contemplates the construction of a floating hospital for the treatment of those who are actually cholera-stricken, so as to carry out the general plan of treating all cases on the water and preventing the disease from obtaining and maintaining a foothold ashore. There is no cause to fear a pollution of the waters of the harbor, for every scientific precaution will be adopted looking to the disinfection of all contagious excreta.

HÆMOLYSIS.

An instructive lecture by Dr. William Hunter upon the fate of the red blood corpuscles, or rather the processes by which they are deprived of their coloring matter, is given in the *Lancet*, December 17. This process, known as hæmolysis, instead of it being an occasional process, consisting in a slow change in the blood, evidenced in the case of the red corpuscles by their gradual loss of elasticity and loss of function, is a daily process involving a daily liberation of a certain amount of hæmoglobin into the plasma of the blood, and its conversion into bile pigments through the agency of the liver cells.

We possess as yet no data for estimating the amount of hæmolysis in health. I conclude that it is considerable, although there is no reason to consider it great. It varies very considerably not only in different classes of animals, but also in different animals of the same class and even in the same individual at different times. It has a certain relation to the general bodily activity, being greatest in youth and early adult life and becoming less as age advances. This relationship, however, is not so much in virtue of bodily vigor *per se* as of the activity of one of the processes usually associated with bodily vigor—namely, digestion. I conclude that if it were not for the changes in the blood associated with digestion the daily hæmolysis would be almost *une quantité négligeable*, instead of being, as I conceive it is, considerable in its amount and still more in its importance. The change which would then occur would be of the nature of a slow decay and would be evidenced in the case of the red corpuscle by its death without disintegration and by the presence of large heaps of blood pigment in

the spleen and liver capillaries. This, however, as we have seen, is not the case; and the difference is mainly to be ascribed to what takes place during digestion. The activity of the cells lying in closest relation to the blood, especially those of the gastro-intestinal capillary area and spleen, affects in the first instance the plasma, and secondarily such of the red corpuscles as are already weakened, and brings about their disintegration. We have seen what the fate of the hæmoglobin under such circumstances is—namely, that it is liable to be carried to the liver and be there broken up into bile pigments, leaving, it may be, not a trace of blood pigment behind.

I conclude, however, that all the hæmoglobin thus set free need not thus be disposed of. To what extent the presence of a certain amount of iron may be necessary for the liver cell to carry out its various functions it is, of course, impossible to say. So far as my observations go I am disposed to think that once it has passed into the liver cell the iron of the hæmoglobin molecule is less available for subsequent use than it is when stored up either in spleen or bone marrow—use, that is to say, for purposes of blood formation. It is this consideration that leads me to think that a considerable part of the hæmoglobin set free during digestion is in all probability utilized at once for purposes of blood formation, without being converted either into bile pigment or blood pigment. For it will not have escaped your attention that the areas which I have described as the seats of hæmolysis—the gastro-intestinal capillary area, the spleen and the bone marrow—are precisely the areas in which blood formation is supposed to go on. That both processes should go on in one and the same place involves no contradiction. It is, on the contrary, what one would expect if, as I believe is the case, the blood is a tissue, and, like other tissues, is under the control of one particular set of cells. The same law holds good for it as for other tissues. It is the wear and tear on the blacksmith's muscle that leads to its great development; so also I conclude, in the case of the blood in health—blood formation and blood destruction go hand in hand, take place in the same areas and are affected by the same conditons. It might be interesting to speculate why this reconstruction should be constantly taking place. This would, however, lead too far from my present purpose, which is to direct attention to the important fact that such is the case.

As to the extent to which hæmolysis occurs in health, it is not necessary to consider it great in order to prove it important. For like many other normal processes, it derives its chief importance from the variations that occur in disease. I conclude the amount of hæmolysis which daily occurs is strictly determined by the degree of activity of the leucocytes of the blood and the mass of lymphoid cells in the spleen and gastro-intestinal tract.

In disease, as in health, hæmolysis is also of an indirect nature. It is not induced by substances having a direct injurious action on the blood. The exceptions to this rule are such affections as paroxysmal hæmoglobinuria and the hæmoglobinuria of burns and scalds and similiar diseases, where the destruction is, as I have elsewhere shown, induced outside the area of the portal circulation, by influences—e. g., exposure to cold or great heat—acting, it may be, over only a limited area. Malaria also exemplifies a disease in which hæmolysis is induced more or loss directly—in its case, by the parasitic action of the plasmodia of malaria on the red corpuscles.

The type of increased hæmolysis of most importance and interest in disease, however, is not that attended by hæmoglobinuria, but that marked by progressive deterioration of the blood and profound anæmia unaccompanied by any such di-

rect evidence of destruction as hæmoglobinuria. Such a disease I have elsewhere, by a lengthy series of observations, shown pernicious anæmia to be. The excessive hæmolysis which occurs in it, evidenced amongst other things by the large accumulation of pigment in the liver, exemplifies, as I have inferred, the action of a poison or poisons of a specific nature produced by agencies acting within the gastro-intestinal area. In respect of its character and its evidences—the changes presented by liver and spleen, the absence of hæmoglobinuria and nevertheless the presence of blood pigment and iron in the urine, the occasional occurrence of jaundice—the hæmolysis of this disease is typically that induced by substances acting indirectly on the blood. So also, I conclude, is the excessive hæmolysis which marks the whole series of toxæmic conditions of which jaundice is a more or less prominent feature, especially of the worst form of all, that condition termed acute yellow atrophy of the liver.

NITRO-GLYCERINE IN PUERPERAL ECLAMPSIA.

At the last meeting of the Tri-State Medical Society (*N. O. Medical and Surgical Journal*, December) R. M. Harbin read a paper on puerperal eclampsia, with report of cases treated with nitro-glycerine.

After reviewing the history of the pathology of the disease, its clinical history and prognosis, two cases were reported treated with nitro-glycerine, 1-100 grain every hour. In both cases the fits were controlled before delivery. In one case two doses were given, in the other three bromide and chloral were also used. In both cases spasms came on before labor began. Nitro-glycerine is a harmless drug. It relaxes vaso-motor spasm. There is an increased reflex excitability in the pregnant state; when arterial contractions are set up this excitability is exaggerated, causing vaso-motor spasm of arterioles of the kidneys, thus producing acute suppression of urine and the consequent symptoms of uremia. By relaxing the spasm the nitro-glycerine relieves the symptoms.

THE ELASTIC LIGATURE AND EXCISION FOR FISTULA-IN-ANO.

Among the various methods of treating fistula-in-ano should be mentioned the elastic ligature and the treatment by excision.

The elastic ligature is principally used in those cases in which the fistula opens into the rectum at a high point, where division by the knife would be accompanied by free hæmorrhage. When employed, a cord of india-rubber one-sixteenth of an inch in diameter is threaded to an eye-probe which is passed through the cutaneous opening into the rectum and brought out at the anus; before tying the ligature, the skin and mucous membrane to the edge of the anus should be divided so that the ligature can bury itself when tied, thereby saving the patient pain and at the same time facilitating the more rapid division of the tissues by the ligature. After the ligature has cut its way through the tissues it is often found necessary to dress the wound in the same manner as in cases where incision has been practised, to secure satisfactory healing.

The treatment of fistula-in-ano by excision has been recommended by some surgeons. The fistulous track being dissected out, the parts are brought together by deep sutures, and if primary union is obtained there is a great saving in the time of treatment. The form of fistula in which this method of treatment is best suited is the complete fistulæ which are not very deep and have a straight course; branching fistulæ, and ones very deeply situated, I do not think are favorable cases for this procedure. If in using this method of treatment it is found that primary union has not occurred, as shown by the escape of a little

pus from the line of incision, the sutures should be removed and the edges of the wound should be separated, and it should be lightly packed and treated—in fact, as a case in which primary incision had been practised.—Dr. Wharton, before Philadelphia County Medical Society.

CHRONIC ARTHRITIS OF RHEUMATIC ORIGIN.

In the *Lancet*, December 10th, Hugh Lane reports an interesting case of the above disease, and commenting upon it says:

The following interesting points show the difference between the two conditions, chronic rheumatoid arthritis and chronic rheumatic arthritis:—1. Family history reveals an utter absence of gout and phthisis, which I have always asserted are found in that of rheumatoid arthritis. 2. No nervous symptoms, neuroses, formication, tingling of limbs, sweating, numbness, pigmentation of skin, and no constitutional symptoms—simply a joint affection; and although every limb is wasted, there is no evidence of general organic progressive disease, as in the rheumatoid arthritis, where the muscular atrophy is one of the earlier symptoms, and, as a rule, precedes the joint affection. 3. Characters of joints affected: all firmly ankylosed, with no enlargement, but of course apparently so, owing to the wasting of the surrounding structures; no effusion, and there are absolute flexion and fixation in this case. Flexions of joints in the vast majority of cases are of rheumatic origin, while in rheumatoid arthritis frequently the fingers are hyperextended, but this is not the rule. The character of the joints affected in rheumatic arthritis contrasts strongly with the condition of the joints in rheumatoid arthritis, where the joints are always swollen, with a sensation under the fingers, as if of fluctuation, the swelling commencing some distance above the joint and terminating some distance below it, and always of a more or less spindle-shape. 4. In this case the temporo-maxillary is the only articulation exempt, oddly enough bringing evidence to prove the correctness of my view, that this joint plays an important part in the differentiation between these diseases, where I pointed out that in rheumatoid arthritis the joints most used are the first to go; and, as everyone must talk and eat, this joint never enjoys a lengthened period of repose, and therefore is frequently the seat of the disease, while in rheumatic arthritis it is rarely affected. 5. Her good spirits; not so in rheumatoid arthritis, when depression is an early and constant feature. 6. The symmetry of the joints affected is another point of distinction, but that is not essential in this case, as nearly every joint in the body is affected. 7. No marked anæmia, which is so prominent a symptom all through rheumatoid arthritis. 8. Slight mitral bruit, but slow acting heart, soft pulse. In rheumatoid arthritis the heart's action is rapid, usually over 100; no anæmic bruit is found, and there is a hard pulse. 9. Although the illness in this case developed before the usual period, the preponderance of evidence points to this being a case of rheumatic arthritis, as described by Mr. Griffiths and myself.

The importance of this proper differentiation cannot be over-estimated, as upon this treatment entirely hinges—the treatment of rheumatism and rheumatic arthritis by anti-rheumatic medication and non-nitrogenous diet, &c.; gout and gouty arthritis by appropriate medical treatment, depletion, diet, &c.; and, finally, that of rheumatoid arthritis, in which case the strumous element so much predominates that it has now caused quite a revolution in the treatment, approximating it to that of struma or phthisis, by cod-liver oil, tonics, stimulation and building up. It must be clearly and distinctly regarded, not as a result of rheumatism or as a hybrid condition, the diagnosis and momenclature of which

were scamped under the absurd appellation of rheumatic gout, but as a distinct disease possessing strong and peculiar features of its own, an offspring of the hereditary tendencies of gout and scrofula. Of course, from the facts of a single case like this it is impossible to deduce any absolute principles, but I hope it will be a link, though a sinkle link, in the chain of evidence which I have previously brought forward in a large number of cases.

Medical Items.

Patent medicines, nostrums, and empirical preparations whose ingredients are concealed, will not be admitted to the World's Columbian Exposition.—*Ex.*

Chas. Willms & Co., this city, make the Galbiati knife which is recommended for symphysiotomy. A figure representing it is given in the *New York Journal Gynæc. and Obstet.*, January, 1893.

Laroyenne states that whenever the finger nails can bring away portions of the cervix or of the uterine mucosa it is perfectly safe to say the condition is one of epithelioma, and no ordinary endometritis. This procedure is so simple and reliable that microscopic examination is practically unnecessary.—*New York Medical Journal.*

According to some statistics collected by the *Riforma Medica*, there is one medical practitioner in Naples to every 513 inhabitants. Medical incomes are steadily diminishing, and are shown by the income-tax returns to be distinctly inferior to incomes earned by members of other liberal professions.—*Medical Recorder.*

Dr. E. Hall Richardson died January 12th at his home in Belair, of Bright's disease. Dr. Richardson was born in Belair sixty-seven years ago, and leaves five children. His wife was Alice A. Wilson. He was past grand warden of Masons at Belair, an active Democrat and an independent candidate against the late Benjamin Filbert for the Senate.—*Sun.*

Dr. Alice MacLean Ross (*Med. and Surg. Reporter*) says: Coffee as a beverage is an agent of considerable potency in drying up the milk of nursing women. In an institution of which I had charge recently, in which there were some thirty or so nursing women, coffee was served twice a week. Regularly upon these days the nurses in charge reported a scarcity of breast-milk, and there was frequently a necessity for resorting to artificial feeding to eke out. There is every reason why coffee should be an excellent agent in reducing the flow of milk, for caffeine is one of the best known diuretics.—*Ex.*

A new method of heating and ventilating railway carriages, patented by Dr. Robert Bell, is now being tried on the North British Railway. An air shaft runs under each carriage, being closed at the distal and opened at the proximal end. The motion of the train forces the air down this tube; a steam-pipe connected with the engine runs through the centre of it and heats the air. The heated air is supplied to each compartment. For tropical climates it is proposed to jacket the shaft with felt, and by keeping the felt moist the evaporation will

render the air in the shaft much cooler than the outer atmosphere.—*American Lancet.*

An officer of the Indian Medical Staff has drawn attention to the great benefit he has found to result from the use of strychnine in the vomiting of debility. In the case of a British officer who came under his charge suffering from obstinate vomiting and great debility due to exposure during one of the recent frontier campaigns, after trying morphine, hydrocyanic acid, bismuth, oxalate of cerium, and most other agents reputed useful in such a condition, he as a last resort tried large doses of strychnine, with the result that the sickness was controlled within twenty-four hours, and after a few weeks the patient, who had previously been simply a living skeleton, was able to go to light duty.—*American Lancet.*

The Regents of the University in New York have adopted a new system of "traveling libraries" which promises to be of much benefit to the people of the State. These libraries consist each of one hundred carefully selected volumes. They are lent to those local public libraries which are subject to the Regent's visitation, as well as to communities where there is now no public library but where twenty-five resident tax-payers unite in application. A moderate sum is charged to defray the cost of casing, transportation, etc. Certain guaranties are required for the safe-keeping and proper use of the books, and some other stipulations have to be made in specific cases. The loan is for six months, at the end of which period there is to be a general shift-about of all the libraries.—*Good Government.*

The Chicago Gynæcological Society held its annual meeting Oct. 28th at the Grand Pacific Hotel and elected as officers for the ensuing year, Dr. E. J. Doering, President; Dr. Fernand Henrotin and Dr. Franklin H. Martin, Vice-presidents; Dr. H. P. Newman, Secretary; Dr. W. T. Christopher, editor; and Dr. A. H. Foster, Treasurer. The President-elect was inducted into office, and adjournment to the banquet room was taken, where, after a substantial menu had been served, the subject of professional entertainment during the World's Fair was discussed by Drs. Earle Etheridge, Jaggard. Henrotin, Ingals, Hotz, Senn, Church, Christopher and DeLaskie Miller. The general sentiment was that entertainment should be carried out individually, and special meetings arranged for very distinguished members of the specialty from abroad. The new President was very happy in the management of the evening.—*Chicago Medical Recorder.*

In view of the possible advent of cholera to this country during the coming summer and the great importance of biological examinations in the diagnosis of this disease, the directors of the Carnegie Laboratory, located at 338 E. Twenty-sixth Street, New York, announce that they have arranged for short courses on this subject, to be open to representatives of health boards, health officers, and to properly accredited medical men. It is designed that these courses shall have the same general scope and fulfil the same purpose as the cholera courses given at the Hygienic Institute in Berlin, by Prof. Robt. Koch, in 1886 and 1887. They will be under the direction of Dr. Edward K. Dunham, who has worked considerably on cholera in Germany and, recently, in this country. The courses will begin about the 20th of January, 1893, and each course will continue for about two weeks. The fee, to cover expenses incurred, wil be $25.00. Applications for admission to the courses should be made in advance to the Directors of the Carnegie Laboratory, A. A. Smith and F.S. Dennis.

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Original Articles.

ASEPTIC SURGERY IN THE HOSPITALS OF PARIS IN 1892.

BY ROBERT REYBURN, A. M., M. D.,

Professor of Physiology and Clinical Surgery, Medical Department Howard University, Washington, D. C.

Having during the past six years made three visits to great Britain and the continent of Europe—viz., in 1886, 1890 and 1892, I have studied with much interest the progress and development of aseptic surgery in these countries. During the summer of 1892 I paid special attention to what I saw of the surgery of London, Berlin and Paris. The present paper will treat only of aseptic surgery as I saw it in the Paris hospitals in 1892. The history of the influence of bacteriological studies in the development of aseptic surgery is one of the most interesting and important of the modern discoveries in the science of medicine. The wildest dreams of our imagination could never have foretold the momentous consequences that would result from the discovery and investigations of the bacteria, and other minute micro-organisms. It is a striking illustration of the fact that we do not and cannot appreciate how far-reaching and important a scientific discovery may be, even when it seems to have no practical use or benefit at the time. To the great Prof. Pasteur's labors, chiefly, we owe the foundation upon which antiseptic and aseptic surgery have been built. He de-

monstrated that the processes of fermentation and putrefaction are entirely due to the presence and action of these microscopical germs, and if they are absent these changes will never take place. This was followed by the labors of Prof. Tyndall, of England, who proved conclusively that if we should exclude completely the living germs or bacteria of the air from infusions of animal or vegetable matter, they could be kept indefinitely.

Infusions, such as beef tea, mutton or chicken broth, and infusions of hay and other vegetable structures, may be kept for years, if after boiling to sterilize or kill the living germs contained in them, they are hermetically sealed to exclude the air which contains the germs. He found also if the mouths of the vessels containing these infusions were plugged up with aseptic cotton to filter out the germs as the air passed in and out, that these infusions could be preserved indefinitely. To Prof. Lister we owe the grand idea of excluding the bacteria and other germs from wounds, and thus creating the then new science of antiseptic surgery. It is perfectly true that antiseptic surgery as now practised in this country and in Europe is very different from, and far superior to, the cumbrous procedures and dressings devised and practised by the father of antiseptic surgery; nevertheless, we must never forget that to Prof. Lister we owe the practical development of the principles underlying what we know to be the true science of aseptic surgery.

The carbolic spray once universally applied has been almost entirely abandoned, and during my recent visit to Europe I never saw it once used. The many layers of protective gauze, mackintosh, etc., are now replaced by a simple layer of iodoform gauze, with an abundant layer of pure aseptic cotton firmly retained by bandages. Another remarkable change is in the growing disbelief in the efficacy of the ordinary antiseptic solutions when used as germicides. Solution of carbolic acid has been shown to be a very good germicide, and the same may be said of solution of boric acid, and of the other solutions commonly used for this purpose. Bichloride of mercury has been our sheet-anchor as a germicide until the present time. As we lost our faith in one germicide after another, we thought we could rely on that. Yet the iconoclasts are busy in their work of tearing down all idols in medicine, and now they have not left us that one. Recent investigations carried on at Johns Hopkins University, and published in the *Johns Hopkins Hospital Bulletin*, of April, 1891, page 50, have shown that solution of bichloride of mercury, when used as a germicide, is often inert and still oftener actually injurious to the tissues, when applied during surgical operations.

The great surgeon, Lawson Tait, believed in no germicide except recently boiled water, and observation teaches us that the consensus of opinion of the great masters of surgery is fast settling upon the conviction that there are only two methods of keeping wounds aseptic: one is to keep wounds made during surgical operations as dry as possible, and the other is to use only recently boiled water in contact with them. Every instrument and surgical appliance must be

sterilized, either by boiling in water containing soda, or by being exposed to dry heat above the temperature of boiling water for at least half an hour.

To this, of course, must be added microscopic cleanliness of the operator, assistants, nurses and all the appliances used in surgical operations, and of course including the operating room and all the surroundings. The present paper will, however, be confined to aseptic surgery as I saw it in three of the Paris hospitals—namely: Hotel Dieu, Hospital Tenon and the Hospital Bichat.

Hotel Dieu, the oldest hospital of Paris, was originally situated on the south bank of the Seine, and the old building is said to have been founded by Clovis II, in the year 660. The present building is located on the north side of the Place Notre Dame, and was rebuilt in the years 1868-1878. It is like many of the hospitals in Europe, quadrangular in shape with a court-yard in the centre, and accommodates about eight hundred and fifty patients.

The hospital is clean and well ventilated. Contagious diseases are not usually admitted to this hospital, but are sent to special hospitals. Some cases of cholerine (so-called) were in the hospital, and I saw a statement in an English paper that one hundred cases of cholera (or cholerine) had been admitted to the Hotel Dieu the day we left Paris. I am unable to state, of my own knowledge, whether any of the cases of cholerine were really Asiatic cholera or not, but I saw in the morgue of the Hotel Dieu several bodies, of patients who had died from this disease.

Hotel Dieu has a very large number of patients attending daily for the purpose of being operated upon, and prescribed for, and these clinics are truly immense. The most famous surgeons of Paris are numbered upon the hospital staff. Those on service at the present time are Tillant, Lancerreux, Verneil, Panas, Proust, Corneil, Brequoy, and Labbe.

Dr. Henri Hartman, whom I met for the first time on August 25, 1892, is also one of the surgeons of the hospital Hotel Dieu, and to him I am indebted for many courtesies during my stay in Paris. He invited me to meet him at the Hospital Tenon on the following day, August 26, 1892. Hospital Tenon is a new hospital containing about one thousand beds, and in point of cleanliness and ventilation was in an admirable condition. I examined with great interest the lying-in ward, and found the most perfect arrangements for antisepsis in them. From 60 to 80 confinements take place there per month, and since the introduction of strict asepsis the mortality from childbirth has been so greatly reduced as to be almost nominal.

The management of all the Paris hospitals is entirely vested in a Council of Administration, who make the appointments of surgeons and directors of the hospitals. All the subordinate positions, such as internes (or what we call resident physicians or students), are filled by concours, or competitive examinations. This same system is applied to the promotion of nurses and other employees of the hospitals. At the last concours out of 627 candidates for the position of internes only 56 appointments were made.

The course of study for a student of medicine in Paris extends over a period of five years, and the college fees amount to almost eight hundred dollars per year.

Bacteriological laboratories are found in nearly all the Paris hospitals and the internes or resident students are evidently familiar with their use, and are in every respect a very high class of men. They are thoroughly competent in the performance of their duties, and in the absence of the senior surgeons are almost daily called upon to perform many of the gravest operations of surgery.

On August 26 and 27, I visited with Dr. Hartman the Hospital Bichat, and found what I considered to be an ideal hospital. Hospital Bichat is small, consisting of only two wards, one for males, the other for females, and each consisting of about 60 beds. These two wards are connected by an operating ward containing ten or twelve beds. There are also the necessary administration buildings. This hospital is used only for operations, and patients who are waiting their turn to be operated upon. I saw there aseptic surgery carried out with a perfection of detail, and such successful results, that I have never seen equalled elsewhere. I saw there six cases of laparotomy in various stages of recovery after being operated upon; cases of cholecystectomy, nephrectomy, vaginal hysterectomy, amputations, and indeed all the graver operations of surgery. Almost all the histories of the cases show recovery without rise of temperature or suppuration. They start out in the Hospital Bichat with the assumption that if an operation is aseptically performed by an aseptic operator on an aseptic patient there ought to be neither fever or suppuration following a surgical operation. If rise of temperature takes place the operator is at once attacked, and blamed for imperfect surgery. If an operator has three or four such cases in succession they have a nickname for him—he is called *cochon sale,* in English, a dirty hog.

Time will not permit me to describe all the interesting surgical cases I saw. Among them was a case of ligation of femoral artery on account of a traumatic aneurism caused by erosion and penetration of the artery by a sharp exostosis on the femur. The artery was cut down upon and ligated above the injured portion with a successful result.

Another case was one of necrosis involving nearly all of the shaft of the femur. After the removal of an immense sequestrum the cavity was filled up by the fresh and aseptic bone from a calf; this was broken up about as large as coarsely ground coffee, and then the cavity was filled up with it, resulting in the formation of a firm and solid bone. This case had been operated upon about six weeks before I saw him, and was about to be discharged cured. Another case of a similar kind was awaiting operation. Dr. Hartman acknowledged that he had received the idea of doing this from an American surgeon, Dr. Senn. On Saturday, August 27, a woman was brought into the Hospital Bichat apparently dying, temperature 107.8, pulse scarcely perceptible, and partly delirious. The case was one of suppurating ovarian cyst, which had burst into the cavity of the peritoneum. After wrapping her in hot blankets, and administration of stimu-

lants, a slight reaction set in, and laparotomy was immediately performed. The next morning at 9 A. M. I saw her and she was rational, pulse nearly normal, and scarcely any fever. It seemed almost like seeing a woman raised from the dead.

The methods of operating are of the simplest character. The arms and hands of the operator and his assistants are of course thoroughly cleansed with soap and solution of corrosive sublimate, 1-2000, as well as the part of the patient's body where the operation is to be performed. As few instruments as possible are used and these have been recently sterilized by boiling water, or dry heat at the temperature of 22° Fahrenheit. No sponges are used, their place being supplied by balls of aseptic cotton. In the case of an amputation no ligatures are used for the vessels except silkworm, gut or catgut, and these are cut short. No drainage tubes are used, or in fact anything that will prevent union by first intention. No plasters are used on the stump for fear of infecting the wound, as it is impossible to sterilize the usual adhesive plasters often used to keep the flaps of the stump in close apposition. The stump is dusted with iodoform, and iodoform gauze is applied, then a liberal supply of layers of aseptic cotton-wool firmly retained by properly applied bandages.

The operator must not of course touch anything from which infection may be conveyed to the wound. He is not allowed to even pass his hands over his own face, or to touch any part of his body during an operation. Such minute precautions as these may seem to some needless, but such is not the case, for, as has been well said, "perfection is made up of trifles, but perfection is no trifle." After a somewhat long and varied experience in surgery, I must say that I have never seen such fineness of technique, and such magnificent results of surgery as I beheld in these Paris hospitals. To Dr. Hartman, as well as to his assistant, Mr. William S. McGill (hospital interne), I am greatly indebted for many courtesies in so freely showing me the cases in the hospital.

It is rare to find a surgeon in Paris to have attained any eminence before the age of fifty years. Dr. Hartman, I am informed, is only thirty-two years old, and is now acting as surgeon in three of the Paris hospitals. With my hearty good wishes I venture to predict for him a brilliant and useful career.

At the meeting of the Clinical Society of London, on November 25th, 1892, Dr. Hadden exhibited two cases of rhythmical rocking movements in children. One was an intelligent little girl aged three years and nine months, who had swaying movements of the trunk and lower limbs when standing or walking. They were not present on lying down. The movements dated from the age of one year, when the child was observed to move the body from side to side when the piano was played, apparently keeping time. She had a good ear for music. The second was the case of an intelligent female child aged one year and nine months, who had rhythmical movements of alternate flexion and extension of the lower part of the spine, with flexion and extension at the hips and knee-joints. The movements had been observed for five months, and no cause for them could be ascertained. They were only observed when the child was sitting down.—*Lancet.*

LESIONS OF THE PERINEUM.*

BY E. E. MONTGOMERY, M. D.,

Professor of Gynæcology, Jefferson Medical College; Obstetrician to Philadelphia Hospital; Gynæcologist to St. Joseph's Hospital.

Gentlemen:—The subject I propose to bring to your consideration to-day is that of lesions of the perineum or of the pelvic floor. The vagina is simply a slit in the pelvic floor; its anterior and posterior surfaces lie in contact. It is not an open canal, as the text-books frequently represent it, but a mere slit. It is about two and one-half inches in length on its anterior wall, three and one-half on its posterior, and into the upper half of this aperture projects the cervix at nearly a right angle to the vagina, when in its normal situation. It is well to remember that under normal conditions the anterior segment lies directly upon the posterior, this being at an angle of sixty degrees to the horizon. Any variation from this must necessarily decrease its ability to support the anterior segment. In the former, we have the bladder with the uterus in its normal position lying upon it, and with the intra-abdominal pressure directed upon its posterior surface.

As the patient stands erect, the intra-abdominal pressure is directed against the pubic bone and the tissue just in front of it. Any lesion in which the posterior segment of the pelvic floor is weakened or destroyed, must necessarily decrease the supporting power of these structures, so that the result will be very soon the turning out of the anterior segment, which will drag upon the uterus, pelvic tissues and fascia, so that we soon have a prolapse or projection of the anterior wall through the vagina, a condition that is known as cystocele. As a result, also, of the laceration of the perineum, we have the coccygeus muscle unantagonized, the anus is drawn backward, and the levator ani muscles wholly or partially torn off so that the rectum sags downward. The result is a prolapse of the posterior wall of the vagina, producing what is known as rectocele.

I now bring before you a patient who has undergone not so much laceration of the perineum as tearing off of the attachments of that important pelvic muscle, the levator ani, by which there results a prolapse of the posterior wall of the vagina. In preparing the patient for operation we have had the external parts carefully shaven, and although the vagina has been irrigated with douches, we will subject her to careful washing with a two per cent. creolin solution, carefully scrubbing the vulva and vagina. The influence of conditions of this kind upon the patient is very great. While we would not maintain, as some do, that the perineum is the only support of the tissues above it, it is a very important part of the structure by which the uterus maintains its normal position, and when it is lost, the displacement of the organs above will be a gradual one. Usually, as a result of the lesion, there is a want of complete involution of the entire genital tract, the uterus remains larger than normal, the vaginal walls are thickened, consequently we have a tendency to displacement of these organs. The more

*Clinical Lecture delivered at the Jefferson Medical College Hospital, October 25th, 1892.

they are displaced, the greater is the interference with the circulation, the tissues remain heavy, and there is still further dragging down. In those cases in which the uterus remains fixed, either from the normal condition of its ligaments or as a result of inflammatory exudation about it, the heavy walls of the vagina dragging upon the cervix leads to its elongation, producing what is known as hypertrophic elongation of the cervix. Thus, we may find one or both walls of the vagina inverted, with the cervix present at the summit of the protrusion, leading us to suspect from inspection that we have to deal with a case of procidentia, but palpation discloses the fact that the cervix is drawn out, forming a cord attached to the uterus, at or near its normal position. Where the uterus gives way under the traction or want of support, its ligaments become elongated and the entire organ may be found in the tumor which projects from the vulva. This tumor is made up of the uterus, part of the bladder, the vagina, and sometimes a portion of the rectum. In all operative procedures upon the perineum, we have in view the replacing of the posterior wall of the vagina in contact with the anterior, so that when the patient lies upon her back there will be no sagging away of the pelvic floor.

As this patient is placed upon her back and the limbs separated, you notice at once a separation of the anterior and posterior surfaces; the vagina stands open and in such cases there is lacking a proper support of the surface and considerable pressure is required to bring the posterior segment up in such a way as to support the anterior. This patient has, in addition to the trouble we have already described, an enlarged uterus with some endometritis. By its weight, it sags down, increasing the probability of protrusion; so we propose first to dilate and curette the uterus, pack it with iodoform gauze and thus promote drainage from its cavity and decrease its size. This procedure I have already described to you and will not take up its consideration now. The dilatation, as you see, is done by graduated bougies; after the cavity is thoroughly dilated we wash it out, use the sharp curette, scraping away considerable thickened mucous membrane. It is then washed out again, and packed with iodoform gauze. This is carried up to the fundus of the uterus, thus making sure that the entire cavity is drained. Now, in performing the second operation, the first consideration, as we have said, is so denuding the surface and introducing our stitches as to re-establish the function of the levator ani muscles and enable them to antagonize the coccygeus. To establish this we pick up the mucous membrane of the posterior wall at the summit of its projection; pick up also the fold of the mucous membrane in the lateral crease of the vagina as it converges toward the vulva upon either side; and connect these by cutting through the mucous membrane with scissors. From the lateral points the surface is again denuded to the junction of the mucous membrane and integument. In this way a triangular section is removed from the upper portion of the vagina, and completed below by an oval section.

Now, instead of introducing our sutures directly across and from one side to the other of this denuded surface, fixing the upper part with a tenaculum, we

introduce the suture downward, bringing it out in the posterior wall of the vagina and then carry it upward on the opposite side, bringing it out of the mucous membrane at a point equally distant from the angle of the wound, at which it was introduced. In this way the introduction of the suture makes with the denuded surface a double triangle. Subsequent sutures are introduced in the same way until the last suture is carried around the margin of the denudation, and brought out upon the opposite side. When these sutures are drawn taut, the central part of the tissues is lifted upward and the result of all the sutures is to lift the entire posterior segment upward, bringing it in contact with the anterior. The result is also that all the sutures are within the vagina and consequently give rise to much less pain than where situated upon the integument of the perineum. Such patients complain very little of the distress, sometimes possibly a little discomfort in the rectum. It may be necessary, in completing the operation, to introduce a few superficial sutures, and as each suture is drawn taut it is held until the next one is tied and if the intervening mucous membrane does not cover the denuded surface, a superficial suture may be placed so as to bring it in contact. The operation completed, we turn this patient about, showing that the vulva opening is decreased, the labia lie in contact with each other, the vaginal canal is again a closed one.

The next patient I bring before you is a woman forty-one years of age, whose father died of consumption, her mother of heart failure; has been healthy as a child, first menstruated at 11, was regular, but suffered from headache before and after. Was always exceedingly irritable during menstruation. She married at 16, gave birth to a child in fourteen months; has had six children, with three miscarriages; first labor very rapid, only lasted about ten hours; second, slow; labors never instrumental. Suffered severe pain in the back at times, also in the coccyx; has been very much depressed; mental condition has been bad; suffers pain in the back, sensation of weight in the pelvis, as if the internal organs were coming down. Want of support of the structure below shows necessarily the increased traction upon the structures of the uterus. The uterus becomes heavy as a result of the interference with its circulation and is still further depressed in the pelvic canal. This is another one of those cases in which the laceration is not marked. There is, however, in her case a displacement of the anterior walls, the posterior wall, and in operating upon her we must take this into consideration. I propose to denude the anterior wall, doing it, however, laterally, rather than the central denudation, introducing the suture in such a way as to draw back the prolapsed urethra. We follow this by an operation on the posterior wall similar to what has already been described, and in so doing we bring again the surfaces in their proper anatomical relation to each other.

As economists, Cincinnati doctors are a success. They entertained the Ohio State Medical Society in May, and had a surplus of $600; also the Mississippi Valley Medical Association in October, and have a surplus of $900.—*Med. Rec.*

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD DECEMBER 16, 1892.

The 273rd regular meeting was called to order by the President, Dr. Wm. E. Moseley.

Dr. Geo. J. Preston read a paper on TRAUMATIC LESIONS OF THE SPINAL CORD, and showed many specimens illustrative of his subject. He considers the medical treatment of traumatic lesions as almost useless, and urges surgical treatment.

Dr. J. W. Chambers said that in the past we have been in the habit of applying certain surgical principles to injuries of the head which we did not apply to injuries of the spinal cord. When a man has an injury to his brain no reasonable surgeon would hesitate to cut down and remove blood clots, etc. The same rule ought to apply to injuries of the spinal cord; we should cut down and remove spiculæ of bone, blood clots, etc., and put the wound in a condition of drainage. The anatomical conditions surrounding the spinal cord are not particularly favorable for the rapid absorption of blood clots. His experience, especially with experimental injuries upon dogs, leads him to believe that the spinal cord is capaple of more repair than is usually thought of. Certain localities of the spine in well-nourished people are very difficult to operate upon, but convenience to the operator should not be a consideration in the case. So long as you do not increase the patient's danger it is all right to operate. While we cannot repair the parts of the cord which are destroyed primarily, we might prevent the injury which comes on secondarily from the pressure of the blood clot and the irritation of the bony fragments. We might in this way avoid bedsores, cystitis, and a number of other sequelæ that are as fatal or more fatal than the injury to the cord proper.

He had known a number of the cases reported by Dr. Preston. One of the cases, a young man, a doctor, was injured by diving in shallow water. He was dragged out by his friends, and in a little while consciousness returned and he suffered intense pain in his arm and was almost totally unable to use his arm and his leg. Twenty-four hours after the injury he had no pain and no discomfort, and was perfectly intelligent. He remained in this condition about forty-eight hours. About six hours previous to his death it was noticed that he began to have a very high temperature, 105 to 108.5, and two hours after death the temperature was 109 in the muscles of the back.

Another case was that of a young man diving in shallow water in almost the same spot as the first and receiving exactly the same injury. He lived three days. No autopsy was held. The diagnosis was fracture of the fifth cervical vertebra. The first twenty-four hours he was apparently comfortable, joking with those around him, and enjoyed his food. The last twenty-four hours before death the temperature rose rapidly and was 108.5 an hour before he died. The temperature was 107 in the rectum two hours after death. A third case was that of a man falling or jumping from a bridge into shallow water and brought into the hospital with symptoms of fracture of the upper portion of the cervical region. He did not have a temperature above 101. There was almost complete paralysis of legs and arms. He lived nearly three days.

Four of the cases related by Dr. Preston were fractured in about the same way,

by diving in shallow water. The head in these cases did not give way, doubtless because it was cushioned more or less by the water. The fracture of the cervical vertebra was probably due to excessive flexion. The most marked flexion would take place about the fifth cervical vertebra and this is the vertebra most frequently broken.

An interesting feature is the rise of temperature. The temperature of a man who had been hanged, when taken by Dr. Chambers fifteen minutes after death, was found to be 102. If the fracture is much above the fifth cervical vertebra the man does not live long enough to let the temperature run up. The higher up the fracture, the more likely we are to have high temperature.

Dr. J. M. T. Finney heartily endorsed what had been advocated by Drs. Preston and Chambers in regard to the surgical treatment of these cases. Very little harm has ever been done by operation, and in a number of cases a great deal of good has unquestionably resulted. Under the present system of antiseptic surgery the question of possible harm being done can no longer be raised against surgical treatment. There is no class of patients that appeal to one's sympathies so much as these unfortunate ones of injury to the spinal cord. Dr. Finney had seen a number of cases almost identical with those related by Dr. Preston. In one case where the fracture was about the seventh cervical vertebra the man lived about six weeks. He had no elevation of temperature.

Dr. Preston said that after injuries to the cord the sensory symptoms improved sooner and to a greater degree than the motor. The thing that kills the patient is often the cystitis and bed-sores and other trophic conditiops, and an operation would probably often allow enough repair to take place to prevent the trophic symptoms. There is no doubt that in a great many of these cases the most important injury to the cord is certainly secondary, due to ensuing inflammation.

These cases are ones for legitimate experimentation, that is, cases of what may be called entire crush of the cord, for they are hopeless as far as medical treatment is concerned.

The work of Abbe and others is certainly suggestive. Whether we can ever do anything by joining nerve roots above and below the injury, as Abbe has tried to do, remains to be proven, but it is barely possible that that or some similar operation may relieve the trophic influences and may allow of sufficient conduction of impulses through the cord to bladder and rectum, etc., to keep the patients alive.

Dr. Edward J. Bernstein read a paper on SKIASCOPY OR OBJECTIVE OPTOMETRY.

Dr. Harry Friedenwald considered this method of measuring the refraction of the eye as one of great advantage. It is the simplest of all the methods and is one that can be easily demonstrated to students. The simplicity of it enables the general practitioner with instruments of great simplicity to measure the refraction easily and rapidly.

Dr. Friedenwald related CASE OF SYPHILIS OF THE EXTERNAL AUDITORY CANAL. The patient was a colored man, 25 years of age. He had a chronic discharge of pus from his ear. The external auditory canal was filled with polypi. He made no improvement on the usual trealment for aural catarrh. It was found that the patient had recently had a chancre and it was seen that the growths had the appearance of syphilitic papules. He was put upon antisyphilitic treatment and within a very short time the polypi had entirely disappeared, leaving a clean auditory canal and a normal drumhead. Syphilis may effect the internal ear or

middle ear but it rarely affects the auditory canal, and this is evidently a rare case.

Dr. J. H. Branham related a CASE OF DRAINAGE OF A TUBERCULOUS ABSCESS OF THE LUNG. The patient has had phthisis for over a year. His lungs were in good condition excepting the middle lobe of the right lung, in which there appeared to be an abscess in the anterior part. The patient was failing rapidly and suffering from an harassing cough. The abscess was cut down upon a week ago and found to contain about a teacupful of pus. The sixth rib was resected over the abscess so as to allow of recession in case of improvement. The patient since the operation has been tolerably well; has some fever. The cavity has been washed out twice a day with antiseptic solutions. The abscess is filling up and Dr. Branham is hopeful that it will heal entirely.

Dr. Chambers asked how much lung had to be cut through before the abscess was reached and if there was much hæmorrhage in the portion of the lung traversed in reaching the abscess.

Dr. Branham replied that the anterior wall of the abscess consisted of lung tissue thoroughly infiltrated with tubercle and there were strong and complete adhesions between the lung and the parietal pleura. The abscess was about half an inch from the surface and the tissue broke down rapidly with the handle of the scalpel and the finger nail. There was practically no hæmorrhage.

Dr. S. K. Merrick told of a PECULIAR CASE OF NASAL REFLEX. The patient came to Dr. Merrick's office on crutches. He had been under treatment for about six weeks for a pain in his right hip. He had a slight hypertrophy of the inferior turbinated bone in the nostril, to which Dr. Merrick applied the galvanic cautery. In twenty-four hours the patient came back without crutches. He is now at work and has perfect use of his limbs.

1519 Broadway. W. T. WATSON, M. D., Secretary.

TRANSACTIONS OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

SECOND ANNUAL MEETING, HELD IN NEW YORK, OCTOBER 4, 5 AND 6, 1892.

THIRD DAY, OCTOBER 6, MORNING SESSION.

A MEMORIAL ON THE LATE DR. GILMAN KIMBALL, by Dr. Ephraim Cutter, of New York.

Dr. Kimball, in addition to being a successful surgeon of wide repute, was specially noted on account of his efforts as a pioneer in ovariotomy, and in both the operative and electrical treatment of uterine fibroids.

RECENT CONCLUSIONS IN THE TREATMENT OF MYOMAS, by Dr. G. Betton Massey, of Philadelphia.

He had had an excellent opportunity of observing the effects of strong galvanic and faradic currents when applied through large electrodes placed on the skin at the upper part of the tumor. The patient was a lady, thirty-three years of age, who had had a very large tumor for ten years past, the softness of which contra-indicated Apostoli's method. Well-moistened pads, about eight inches in diameter, were placed on the tumor, and on the back, and first a current of 150 to 200 milliamperes employed, and, afterwards, strong faradic currents from a Du Bois-Reymond coil. After each treatment, the tumor becomes harder, and there was a shrinkage of from one quarter to one-half inch, and at the end of two and a half months of treatment, there had been a reduction of two and a half inches in circumference. The author also reported seven cases in which

tumors had entirely disappeared under the use of electricity. Six of these were treated intra-uterine, and one by puncture. To be most effective, the method requires that the current be concentrated in the immediate vicinity of the trophic and vascular growth of the tumor, rather than simply passing through the tumors.

Dr. Kellogg said that the faradic current exerts a powerful effect on uterine tissue, but he had never seen any permanent arrest of a growth of neoplasm. In order to accomplish this, there must be a destruction of the blood vessels which supply the tumors, and for this purpose, an electrolytic current was most suitable.

Dr. Hutchinson described a method of treating uterine fibroids by the use of mild currents divided among six fine needles, three to five milliamperes each, which are driven through the abdominal walls into the tumor. The method was very slow, but was free from danger. In one case, dying of pneumonia about a year after the treatment had been discontinued, he was able to obtain an autopsy, and while he found several hundred needle marks on the uterus, there was not the slightest evidence of peritonitis having occurred. The indifferent pole was a pad, six or eight inches square, applied to the back. The needles were not insulated, as this interfered with thrusting them through the skin. So far as he had formulated any theory, it was that the electricity acted as a stimulant to the absorbents.

Dr. Dickson said that he had been accused of producing suppuration by the use of currents not exceeding 20 milliamperes, applied internally through a platinum sound. He would like to know the experience of others on this point.

Dr. von Raitz said that when employing the currents of seventy or eighty milliamperes in the treatment of endometritis, he had frequently met with necrosis.

Dr. Kellogg said that if a metallic surface of the electrode were brought directly in contact with the tissues, a current of 10 milliamperes would produce sloughing. These tumors are cured, in his opinion, by setting up a necrosis, or a circumscribed phlebitis which cut off the circulation from the neoplasm. Dr. Hutchinson's method on account of having no such action was well worthy of trial. Reasoning from the evident anæmia produced by the mild current used in epilation, he thought it probable that it was by a similar process that Dr. Hutchinson obtained his good results.

Dr. Massey, in closing the discussion, said that the faradic current would apply to myomata rather than to fibroids; it caused an immediate contraction, which, while not permanent, might be an important adjuvant to the electrical treatment of fibroids. It would not be necessary to affect the vascular supply; we might perhaps accomplish our purpose by acting upon the nervous supply of the hilum of the tumor. He had tried Dr. Hutchinson's method of puncture, using, however, insulated needles, and strong currents, and while the results had been good, they were not so good as he had obtained by punctures near the hilum of the tumor. Necrosis may have occurred in Dr. Dickson's case, as it exists not infrequently in cases which had never been treated electrically. The current ordinarily produces a cauterization, but this should not be confounded with necrosis, which may occur in the adjoining tissues.

THE PRESENT STATUS OF ELECTROLYSIS IN THE TREATMENT OF STRICTURES, by Dr. Robert Newman, of New York.

The author said that his statistics now embraced a total of 300 cases, and his later experience only confirmed his former claim that electrolysis, scientifically

applied, is absolutely successful. He had practised this method successfully for over 23 years. It is applicable to all strictures, and in any part of the urethra, and will enlarge a stricture when other methods have failed. The method was painless; it was unattended by pain, hæmorrhage or fever; it gave immediate relief; it did not prevent the patient from attending to his business, and when properly done there were no relapses. He employed a constant current of only from three to five milliamperes, with the negative electrode applied to the seat of stricture. The seances lasted not more than five or ten minutes; only one instrument was introduced into the urethra, thus lessening the chances of infection, and the treatment was never employed when inflammation was present.

Dr. S. T. Anderson, of Bloomington, Ill., said that he understood that the author did not recommend this treatment for traumatic strictures. He had, however, employed it in a number of such cases, and with excellent results, the only difference being that he employed stronger currents. Some of the cases had been cured at one sitting, and the cures were all permanent. The author would most likely condemn this heroic treatment, but the great point was that it was successful.

Dr. D. S. Campbell wished to corroborate Dr. Newman's claims by stating that in a series of 56 cases which he had treated by this method, the results had been excellent; many have showed no recurrence when examined four or five years afterwards. As the treatment was frequently followed by urethral catarrh and more or less congestion it was not advisable to employ currents of more than five milliamperes, and the treatment should not be repeated oftener than once or twice a week. He also referred to the success of this method in a somewhat analogous condition—stricture of the œsophagus.

The Association then adjourned in order to accept the invitation of Mr. Thomas A. Edison to visit his laboratory. On arriving there they were most courteously received and entertained by Mr. A. E. Kennelly and his assistants, and a most enjoyable afternoon was spent in inspecting this wonderfully complete laboratory.

At a recent meeting of the Pathological Society of London (*Lancet,* December 10th) Dr. Anderson showed a specimen of chronic mastitis from a man aged thirty-five. The gland began to enlarge six months before the patient came under observation. It commenced without apparent cause and was gradual and painless in progress. It was hemispherical in form, about an inch and a half in diameter at its base, moderately hard to the touch and slightly tender. It was removed at the end of May, 1891, and was found to consist of new fibrous tissue developed around the elements of the gland. Under the microscope the ducts and acini presented no especial change, but around each duct was a distinct area of proliferation, and beyond this the new fibrous tissue was arranged concentrically. The patient was still quite well, but it was worthy of remark that the scar underwent a cheloid hypertrophy. Chronic mastitis in the male in later life was not specifically referred to in the text-books, but it appeared to supply a missing link in the pathological analogies of the male and female mammæ, completing the series of evolutionary reactions exemplified in the mastitis neonatorum and mastitis of puberty so well known in both sexes by furnishing a counterpart to the climacteric mastitis of women. The tendencies of the condition were doubtful, whether towards resolution, cirrhotic contraction or malignant degeneration.

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BALTIMORE, JANUARY 28, 1893.

Editorial.

IS BALTIMORE SAFE?

We should be very glad to hear from our readers of any precautions which the Health Board of Baltimore is now taking to preserve our city from cholera when its wave of invasion again moves westward.

Strange to say, the Charity Organization Society seems to be the only institution which has taken a broad view of the situation and attempted through the press to create a public demand in protective measures. The interest of the business portion of the community seems to extend only to the unjust discrimination against the commerce of the city resulting from the medley of local and national quarantines on the Atlantic sea coast.

Boston is ahead of us in provision against the scourge, as is shown by the extract given below.

BOSTON'S PREPARATIONS FOR THE CHOLERA.

To those who take an interest in the establishment of necessary measures for the protection of our city against cholera invasion which is expected next summer, it will be of interest to note what sister seaports are doing in this matter.

In a recent issue we noticed the precautions taken by New York. We now present a clipping from the Baltimore *Sun* showing what preparations Boston has made:

The Charity Organization Society of Baltimore has obtained from Boston officials replies to a number of questions regarding Boston's preparations for a cholera emergency. The result of the correspondence follows:

"The board of health of the city of Boston has made the following provisions: On the arrival of the infected ship at quarantine all persons having the disease and all immigrants will be removed at once to one of the islands in the harbor,

where ample accommodations have been provided for their care. If an outbreak occurs in any part of the city, hospitals have been provided and are in working order, where all persons ill with the disease can be taken at once, and the premises where they resided will be properly disinfected.

"Additional measures will be taken on the near approach of the disease, such as issuing pamphlets, etc. The board of health, of which Samuel H. Durgin, M. D., is chairman, will give any information to any person interested in the subject.

"The local board of health constituted itself a committee of emergency as soon as there was danger of cholera, and our citizens are in the habit of looking to them for action in all matters referring to the public health. Their powers are great, and practically only limited by the appropriation of the city council.

"Within six weeks there have been completed under their direction two buildings on Galloupes Island, in the harbor, for receiving immigrants. They provide together sleeping accommodations for about 700, and are intended for well people held in quarantine. A disinfecting station has also been built there. There are stored on the island a number of portable buildings formerly used as polling booths, which will make excellent temporary hospitals for summer use, and also many tents. There are many other booths stored in the city proper, which are retained for use as polling booths, but in an emergency even these could be taken by the city for hospital service. They are wooden buildings, which can be taken apart, and at the election time are set up in the streets for temporary use.

"The board of health has also built in the city proper, on Swett Street, a new hospital, to accommodate about sixty patients, and on the same lot of land a disinfecting station. This station will be used for disinfection of clothing, &c., in case of scarlet fever and other contagious diseases when it is not convenient to have the clothing disinfected at the house. Two new ambulances are being built to be used exclusively for cholera.

"The chairman of the board, Dr. Durgin, made a list last summer of physicians who consented to be called upon in case of a cholera epidemic. They were naturally among the younger physicians, and if the board of health had found it necessary to employ them, they would, doubtless, have been paid by the city.

"The most important measure of precaution, in the opinion of the board, would be an appropriation sufficient to employ continuously a corps of men who would keep the yards and passage ways absolutely clean. Under the pressure of excitement last fall a very thorough cleansing was put through, but it ought to be done all the time, and the only reason the board of health does not do it is the want of money."

An ordinance has been submitted in the First Branch of our City Council by President Seim, appropriating $20,000 to erect a monument to Johns Hopkins.

Reviews, Books and Pamphlets.

The Physician's Complete Book of Records. Compiled by SAML. E. WALKER, Ph. G., M. D.; published by the Keystone Publishing Co., Philadelphia, Pa. Price $5.00.

No physician's office can be quite complete without this book. It is a perfect ledger showing at a glance a daily record of visits and daily cash accounts. It shows at the end of the month a correct and clear statement of each patient's account. The monthly balances are transferred to a continuous ledger section containing successive columns for balances, dates and payments. The book also contains an obstetrical record, a record of deaths, and memoranda useful for making notes of a great variety of occurrences. Its simplicity, accuracy, brevity and neatness will commend it favorably to every physician. It will render the keeping of accounts so simple that errors will be practically impossible.

Seventeenth Annual Report of the President of the Johns Hopkins University. Baltimore Md., 1892: Johns Hopkins Press.

This pamphlet presents to the public a full report of the progress of the University during the year; its advances and its needs; the lectures which have been delivered in it by eminent men from outside, and the work done by its own staff; and the gifts to the University by its friends and well-wishers.

The Columbia cycling calendar for '93 is the most exquisite and truly artistic of practical calendars for the year. It begins with February, '93, and ends with February, '94. It consists of a circular piece of cardboard, 47 inches in circumference, the calendar picture being framed with a reproduction of the pneumatic rubber tire. The picture is in fifteen water colors, and represents a country scene with a bicycling couple in the foreground, resting in a cosy nook, after a delightful ride. The original picture is by a celebrated American artist, and the reproduction is so close to the painting that one hardly realizes that the delightful tones and shades are not the true brush marks. This calendar, issued by the Pope Mfg. Co., of Boston, is adapted for the library, dining-room, parlor, or business office.

Medical Progress.

MARYLAND AND THE CHICAGO EXPOSITION.

In accordance with a request received by the Johns Hopkins University trustees from the committee on Education of the Board of World's Fair Managers of Maryland, that a committee be appointed to undertake the work of preparing a book upon the resources of Maryland, as requested by the Board of World's Fair Managers of Maryland, and that the said committee consist of Messrs. G. H. Williams (Chairman), Wm. Hand Browne, W. B. Clark, H. B. Adams, N. Murray, W. K. Brooks, and M. Whitney, together with the President of the University *ex officio*, the committee was appointed.

The Committee thus appointed at once organized and elected Dr. William Hand Browne, Editor-in-Chief; Drs. Herbert B. Adams, Wm. K. Brooks and George H. Williams, Associate Editors; and Dr. William B. Clark, Secretary. Mr. N. Murray and Dr. Milton Whitney, the remaining members of the com-

mittee were vested with advisory functions, and Mr. J. H. Hollander was appointed assistant to the editorial board.

The general plan of the book has since been outlined and some preliminary work done. In form the volume will be a quarto of about five hundred pages. It will consist of five main divisions, each of which has been placed under the supervision of a member of the editorial board. Dr. Browne, in addition to his general duties as editor-in-chief, will contribute an introductory sketch of the history of Maryland.

The first division relates to the Physical Features of the State, and is in charge of Dr. William B. Clark. The geographical divisions, the drainage system and the water supply of the State will be described in detail. Under the head of Climate, attention will be paid to temperature (with tables showing daily, monthly and yearly variations), winds, barometric pressure, atmospheric precipitation and general healthfulness. The health and pleasure resorts of the State, and their importance and proximity to the larger cities, will also be treated.

The second division is devoted to the Geology and Mineralogy of Maryland, and will be prepared by Professor George H. Williams.

The third division, relating to Agriculture and its interests, is under the direction of Professor Milton Whitney. The statistics of the 11th census, showing the principal crops of the State, the average yield per acre, and the value of farms and farm products, will be reproduced. Attention will be paid to the cost of labor in different parts of the State, and the leading causes which are changing Maryland agriculture, and the direction it is taking. The principal varieties of soil found in the State, their relation to the development and distribution of particular crops, and a general summary of the agricultural features of the State, with the advantages offered in the different agricultural regions, constitute other important features of this division.

The chapter will also treat of various special lines, such as the dairies, creameries, fattening of cattle and the canning industries, and in a general summary it will treat of the general agricultural features of the State and the advantages offered in the different agricultural regions.

Professor William K. Brooks will prepare the fourth division, devoted to the flora and fauna of the State. The animal life of Maryland will be treated in detail. The fisheries of the State will also be described, the oyster coming in for a large share of attention.

The fifth section, which is expected to form nearly one-half of the entire volume, will be devoted to the industrial and institutional interests of the State. It will be prepared by Mr. J. H. Hollander, with the co-operation of a number of specialists, under the general supervision of Prof. H. B. Adams.—*Johns Hopkins University Circular.*

PROFESSIONAL OVERCROWDING.

Nowadays, and in every calling, we are liable to be constantly reminded that the ranks of workers are becoming inconveniently overcrowded. The statement has no doubt some foundation in fact, and it is one which conveys a very practical meaning to members of our own profession, which is at no time so overpaid that it can bear a lavish distribution of its emoluments. Fortunately the assertion admits of qualification. A comparison of medical practice in various large centres of industry, including the metropolis itself, has shown that the total number of resident practitioners has not grown in proportion to the increase of the general population. Overcrowding has in this case a relative rather than an

absolute meaning. The number of workers is not disproportionate, yet work and income alike tend rather to restriction than to excess. We must therefore look to other causes than mere congestion within the profession itself to account for this fact. Among these we should probably include the development of specialism. Sufferers who would in a past generation have sought counsel of their nearest medical neighbor flock in crowds to some one or two who are supposed to hold the key to their constitutional secrets. The profession as a whole must lose in proportion, and often by no means justly. Another prime cause is to be found in the competition of hospitals. The abuse of charity evident for some time past in many such institutions has latterly undergone, it is true, considerable abatement under the exercise of stricter methods of inspection, so that some relief of professional over-pressure may be looked for in this direction. Clubs and dispensaries again exert a similar but an even more deleterious influence. They are, as a rule, far too little subject to regulation as to the status of patients admitted to the charitable relief—for it is nothing else—which they afford. More than this, they are often administered, if not owned, by medical men themselves engaged in family practice, who for the sake of some supposed profit, either in means or in reputation, connive at impositions by well-to-do persons which are under any circumstances absolutely disgraceful. Such are some of the influences at work in every considerable centre of population, which, in spite of a correct statistical relation between the number of practitioners and of the local population, maintain a state which virtually tends to overcrowd and to starve out the former. We need hardly point out the fact that the true remedy for such conditions is to be found not among the regulations of licensing bodies or local authorities, but in the self-respecting decision of medical practitioners themselves.—Editorial in *Lancet*.

ESTLANDER'S THORACOPLASTIC OPERATION.

At a recent session of the Royal Academy of Medicine in Ireland (*Brit. Med. Jour.*) Sir Wm. Stokes discussed the cases of empyema in which drainage would be likely to be sufficient, and those in which a plastic operation such as Estlander's was required. The particulars of a series of cases operated on by Sir William Stokes and his colleague, Sir P. C. Smyly, were detailed, the results of which were, on the whole, most satisfactory. The results of the experience derived from the cases operated on in Dublin tended to show that ultimately the operation would be deemed applicable to a much larger range of cases than at present. The views of Mr. Godlee and Mr. Heuston as to where the opening into the cavity of the pleura should be made were considered, the author being of the opinion that the situation recommended by them would be, in the majority of instances, perilously near the diaphragm. The question of flushing the pleura was also discussed, the author giving his approval to the practice both during and subsequent to the operation.

Mr. Heuston said that in the performance of Estlander's operation it was important that the periosteum of the rib should not be preserved to too great an extent, as it was liable to form new bone to such a degree as to do away with the object of the operation. In the more recent cases he turned the flap of the periosteum over the end of the rib where it had been cut across, and thus hindered the absorption of the discharge by the cancellous bony tissue, to which he ascribed the immunity of his patients from pyæmia, which some authors considered the greatest danger from this operation. He had never injured the diaphragm in the many operations he had performed, although he always selected

the eighth interspace in the scapular line for his incision; this position presented a great advantage over those incisions made on the anterior or lateral chest wall, in the fact that here the ribs were so fixed by their vertebral attachments that there was no danger of the tube being occluded by the ribs falling together. In recent cases he employed only one washing, namely, at the time of the operation, to remove any semisolid lymph which might be within the pleural cavity, and he had found that by the occasional introduction of an antiseptic which dissolved slowly within the cavity, even where the discharge was fœtid at the time of the operation, it became quite sweet within a few days, never to resume its fœtid character.

THE CARE OF THE HANDS.

The first point to be considered in the care of the hands is cleanliness. There are a few standard rules upon this subject. Very hot water should be avoided, except in cases of severe chapping or frostbite; and then, before the hand is put into the water, some sort of an emollient should be rubbed thoroughly in. Tepid water and good unscented soap should be used, as a rule, to wash the hands. If glycerine agrees with the skin, which it does not in all cases, it should be used while the hand is wet. If gloves are worn at night they should be very loose and the tips of the fingers cut off, else there will develop a dryness of finger nails and skin, which is neither beautiful nor pleasant. Regarding manicuring of the nails, it is a great mistake to use the scissors upon the scarf skin. A blunt stick dipped in a mixture of lemon juice and glycerine will do very much better work. A red hand is never pretty, and to guard against this or to overcome the defect when present, great care should be exercised in washing the hands. A dry wash of Indian meal and soap, and perhaps a little glycerine, rubbed thoroughly into the skin, is the best remedy for this. Pure white Castile is unquestionably the safest soap. Rubbing the hands together gently after washing tones the skin, equalizes the circulation and does away with redness. Five or six grains of chlorinated lime dissolved in a pint of lukewarm water will whiten the hands more than any other application. Redness and warts may be cured by this recipe by soaking the hands in this mixture for ten minutes at night and morning.—*Baltimore Sun.*

A SINGULAR MEDICO-LEGAL CASE.

At a recent meeting of the Societe de Medecine Legale an interesting communication was made, on behalf of Professor Cazeneuve, on a singular case of infanticide involving a somewhat unusual medico-legal problem. It was a question concerning an infant of five months which had died suddenly in 1891 without showing any previous symptoms of disease. At this time there was no suspicion of crime, and it was only owing to certain rumors, sixteen months later, that the police took action and caused the body to be exhumed. The chemical analysis for traces of arsenic, lead, mercury and other poisons came to nothing. However, further research led to the discovery of eight small pieces of an elastic blackish-grey substance blocking up the intestinal tract. After repeated washings and careful examination these were recognized as portions of sponge, and M. Cazeneuve was of the opinion that the ingestion of these fragments of sponge was the cause of death. In support of this opinion he cited the custom which obtains in certain country districts of killing stray dogs and predatory cats by placing in their way small pieces of sponge soaked in grease, which, upon being swallowed by the animals, become swollen in the intestinal canal, after the manner of a sponge tent, and thus induce fatal obstruction. Founding an

opinion on these considerations, and also taking into account the fact that the portions of sponge presented a well-defined cut surface, the medical jurist concluded that circumstantial evidence was established that the child was caused to swallow the pieces of sponge in a vehicle such as milk or soup. The jury also took this view, with the result that the accused was sentenced to penal servitude for life.—Paris correspondence of the *Lancet*.

FRIEDENHEIM: A HOME FOR THE DYING.

Death must always be accompanied by circumstances of sadness, but the conditions under which dissolution approaches are in some cases peculiarly distressing. In only a few hospitals is accommodation provided for patients for whom all hope of recovery has to be given up. Therefore the humane project started by Miss Davidson some seven years ago, which consisted in founding a Home for the Reception of the Dying, cannot but enlist the sympathy and aid of the benevolent. The Home, situated in the Upper Avenue-road, St. John's Wood, was opened on the 10th instant by the Duchess of Teck, in company with Princess May and her brother, the Prince Adolphus. The history of the movement was recounted by Dr. Schofield, who has taken great interest in the enterprise, and who entered into some particulars in connection with the working of the institution. It appears that the patients at the home die on an average in three months, but the care bestowed on them is rewarded in some instances by restoration to health. Except in the paying wards the beds are free, preference being given when a vacancy arises to the most distressing cases. The Home will accommodate forty inmates.—*Lancet*.

DURATION OF LEPROSY.

A medical man recently returned from a holiday in South Africa has given some interesting details as to how long a leper lives. Robben Island has been used as an asylum for South African lepers since 1846, but it was not until twenty-five years after that date that a death occurred. During the twenty-five years, however, only fifty-seven patients were admitted. From 1871 to the present time an average number of twenty-four patients have been admitted yearly, an average of ten discharged, and an average of twelve have died each year. According to the statistics from the year 1846 to the end of 1891, five hundred and seventy-nine patients, suffering from leprosy, landed on the island, of whom two hundred and two were discharged and two hundred and fifty-seven died, leaving alive on the island at the end of 1891, one hundred and twenty lepers. Of the two hundred and fifty-seven who died, two hundred succumbed before they had been four years on the island, and most of the remainder before they had sojourned there twelve years. Five cases lived over twelve years, one fifteen, another seventeen, another eighteen, another twenty-six, and another forty-five.

Of the living patients now on the island, one has been there twenty-two years, another nineteen, another seventeen, another eleven, another ten, and the remainder less than that period. From experience gained on Robben Island it is found that leprosy is generally contracted between the ages of fifteen and twenty-five; it develops very slowly, so that the patient does not require much medical aid before the disease has run four years; the majority of lepers die within five years of their admission to the hospital; the average length of life of a patient after the development of the disease is nine years.—*American Lancet*.

A WANDERING SPLEEN EXCISED.

In the *Lancet* of December 17, 1892, we learn that Dr. Sutton communicated to the Clinical Society, December 9th, the details of a case in which he had performed splenectomy for a wandering spleen. The patient, a married woman

aged twenty-two, mother of one child. became aware of the existence of a swelling in the left half of the abdomen. In March she was seized with acute pain in the tumor, accompanied by vomiting and diarrhœa. On her admission to the Middlesex Hospital the tumor, which was very mobile, resembled hydronephrosis of a movable kidney, but the diagnosis was eventually reduced to a hydatid cyst of the omentum or a wandering spleen. On March 21st an exploratory operation was undertaken and the swelling proved to be a greatly enlarged spleen, with a twisted pedicle. The pedicle was untwisted and the spleen returned to the left hypochondrium. The patient lost her pain, rapidly convalesced and left the hospital wearing a carefully adjusted belt. Six weeks afterwards the spleen was in its normal position and apparently of proper size. On July 7th the patient came again to the hospital with a return of her trouble; the "lump" had appeared again and she was suddenly seized with acute abdominal pain, vomiting, diarrhœa and hæmorrhage from the vagina. After consulting with his senior colleagues, Mr. Sutton advised the patient to submit to removal of the spleen. In order to give some idea of the wandering capabilities of the spleen it might be said that on July 9th it was in the right iliac fossa in front of the cæcum. On July 10th it was in the left iliac fossa, resting on Poupart's ligament. On July 12th it was in the pelvis, its lower end resting on and doubling up the uterus. Splenectomy was performed on July 12th, the abdomen being opened through the scar of the first operation; the incision extended from the umbilicus to the symphysis pubis. The pedicle was twisted through three complete turns and with its distended veins looked like a huge umbilical cord. The pedicle was transfixed and tied in two halves with thin but strong plaited silk and then encircled with a separate ligature for safety. The wound was closed in the usual manner. The patient was treated as after an ovariotomy and recovered without the least drawback. The spleen weighed sixteen ounces, and though of an unusual shape was in texture quite natural. Observations on the numerical strength and proportions of the blood-corpuscles were made before and subsequently to the operation, and it had been arranged to continue them for some months to come.

KERATO-MALACIA.

At a recent meeting of the Ophthalmological Society Dr. Holmes Spicer read a paper on Kerato-malacia in Young Children. These subjects were more liable to gangrene of the cornea than adults when their vitality was reduced below a certain level. The gangrene might either be spontaneous or the result of comparatively mild attacks of conjunctivitis. In the late stages of tuberculous meningitis and infantile diarrhœa the cornea underwent destruction, this being due partly to exposure and partly to insensibility. After measles or whooping-cough, with bronchitis and malignant varicella, where there had been much exhaustion, the cornea was not infrequently seriously damaged by large perforating ulcers. After serious malnutrition the cornea might slough spontaneously, as was not uncommonly seen among nurslings in countries where the mothers practised long religious fasts. In this country it was rare except among the hand-reared who had had insufficient nitrogenous diet. The affection generally attacked both eyes of children from four to nine months old; it began with dryness of the conjunctiva, with patches of froth on its surface and with night blindness; soon the whole cornea became opaque and perforated, the termination being very often fatal. In treatment a principal feature should be the increase of the nitrogenous constituents of food, some meat juice or raw meat finely powdered, in addition to milk for young babies, and cod-liver oil. Locally eserine in the form of ointment should be applied to the eye, with warm applications to the lids. Some of the cases under this treatment made a good recovery; in one case the cornea re-

covered, although the child eventually succumbed. The President alluded to the disease as met with in adults, and mentioned a case he had recently seen in a woman completely crippled by arthritis deformans. Mr. Drake-Brockman said he had met with many cases of kerato-malacia in India in times of famine, during epidemics of cholera and not infrequently in association with chronic dysentery. He thought the condition in children was often associated with congenital syphilis. In many cases destruction of the cornea occurred with extraordinary rapidity. Mr. Doyne mentioned the case of a child of six weeks in whom, after this condition, the cornea cleared almost completely. Mr. Priestley Smith (Birmingham) dwelt upon the necessity of keeping a careful watch upon the cornea in children and others prostrated by serious illness. The cornea was often exposed during sleep and prone to severe ulceration. Protection of the cornea by a bandage, or adhesive plaster on the eyelids, would often prevent this dangerous complication.—*Lancet.*

Medical Items.

A meeting was held on January 13th in the Board of Trade rooms in the interest of a municipal hospital for infectious diseases, combined with a plant for disinfecting infected material. Those present represented the Charity Organization Society, the Medical and Chirurgical Faculty, the Board of Trade, the Corn and Flour Exchange, and Taxpayers' Association. A committee made a report, which was signed by Messrs. Charles J. Bonaparte, William H. Welch, Samuel T. Earle, Jr., W. G. Atkinson, P. C. Williams and Frank Kerr. The report strongly urges the establishment of the hospital. It says that hospitals for the care of infectious diseases do not endanger the health of those living in the neighborhood, and declares that they lose their usefulness when placed in inaccessible localities. It advises the adoption of the pavilion principle, with separate buildings, and suggests four pavilions, with forty beds, for present needs. It also suggests the appointment of a commission with power to acquire a site and supervise construction. Ex-Judge William A. Fisher made a motion to accept the report and authorize the committee to apply to the City Council for the necessary legislation to get the hospital. The resolution was unanimously adopted, as was one commending Health Commissioner McShane for his efforts in the same line.—*Sun.*

The annual report of the board of managers of the Maryland Hospital for the Insane at Spring Grove has been issued. Mr. Wilmot Johnson is President of the Board and Dr. George H. Rohe is Superintendent of the Hospital. The whole number of patients treated in the year ended October 31st, 1892, was 501, of whom 270 were males and 231 were females. Thirty-two patients died in the course of the year. Among the supposed causes of insanity of those who were admitted to the hospital were the following. Business perplexities, 3; domestic troubles, 5; grief at loss of friends, 1; intemperance, 4; epilepsy, 5; opium habit, 3; traumatism, 3; influenza, 3; sunstroke, 3; overwork, 3; puerperal condition, 5; sepsis, 1; and meningitis, 1. The report says: "We hope the next Legislature will appropriate a sufficient sum for the building of another asylum, on the Eastern Shore, or elsewhere, which is greatly needed, owing to the increase of the insane. We think it would be inexpedient to enlarge the present institution, without incurring great risk. We require all the land we have for our present use." The report contains articles on medical subjects by Dr. Rohe and by Drs. J. Percy Wade, Milton D. Norris, Frederick Caruthers and John H. Scally, Dr. Rohe's assistants at the hospital.—*Sun.*

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ADDRESS ON PEPSIN.*

BY J. LE ROY WEBBER, PH.G., OF BALTIMORE.

Mr Chairman and Gentlemen:—Ever since antiquity the digestive function of the stomach has been known, but it was not until the year 1836 that Schwann discovered the "digestive principle" in the gastric juice, and three years later Wasmann and Papenheim succeeded in extracting pepsin. In the year 1854 it was introduced into therapy by Corvisart, the body-physician of Napoleon the Third.

A chemical formula for pepsin has never been determined, as it has never been isolated in an absolute state of purity. It is, however, composed of the same elements as the albuminoids, with which bodies it is usually classed.

Owing to its peculiar properties it belongs to the ferments, that is, to those nitrogenous bodies which in the presence of water and at moderately warm temperature are capable of producing certain chemical changes in other substances without themselves undergoing a substantial change.

In the animal economy we find a number of such ferments secreted at different points of the alimentary canal. The ptyalin of the saliva, pepsin of the gastric juice, trypsin, steapsin and amylopsin of the pancreatic fluid, and the en-

*Delivered at the Meeting of the New Yorker Deutscher Apotheker Verein, December 8, 1892.

teric ferments all play an indispensable part in converting the food we eat into a soluble and assimilable condition. This process we call digestion, the perfect operation of which is so essential to health and necessary for proper assimilation of food and consequent replenishment of wasted tissues.

As the stomach is considered by many the most important of the digestive organs, it is but natural for us to regard pepsin, its chief digestive principle, as a most important factor in gastric digestion. If nature fails to provide a sufficient quantity of this proteolytic ferment owing to weakness or disease, then it is that the administration of pepsin is indicated. That pepsin is of value as an aid to certain forms of digestion is an acknowledged fact, and, while physicians occasionally report unfavorably regarding its use in medicine, I am disposed to ascribe such failures to incompatible combinations, or to the comparative inactivity of the pepsin employed. It is, therefore, an absolutely necessary requisite that the pepsin used should be of high power and that nothing be combined with it to destroy its efficacy.

As the incompatibles of pepsin are of particular interest to the physician, I will pass this subject in order to enable me to speak more at length on the progress which has been made during the past twenty years in the manufacture of commercial pepsins.

One of the principal methods in use prior to, and since 1870, consisted in merely scraping the pulp from the cleansed mucous membrane of the pig's stomach and then powdering it, after being properly dried. Viewed from our present knowledge a more unwholesome preparation could scarcely have been devised.

In 1871, one year before the discoveries of Mr. Emil Scheffer laid the foundation for a new pepsin era, Dr. J. B. Hawley published an article in the *American Journal of Pharmacy* on the "digestive power of commercial pepsin." The four brands tested were Houghton's, Grimault's, Boudault's and Hawley's. The first of these gave negative results, or "digested nothing," while the other three digested respectively 4, $8\frac{1}{5}$ and $10\frac{2}{5}$ times their weight of coagulated egg-albumen.

One year later Scheffer made known his method of separating crude pepsin from the cold macerate of pigs' stomachs by precipitation with sodium chloride, and adding sufficient quantity of sugar of milk to the pepsin precipitate to make one grain of the saccharated product dissolve twelve grains of albumen. By resolution of the first precipitate in acidulated water and subsequent precipitation, a purified article was obtained which was capable of dissolving 500 times its weight of albumen, in six hours, at 105°F.

Following the researches of Scheffer there appeared on the market the so-called peptone or soluble pepsins having a digestive power varying from 350 to 1000. In preparing these pepsins the mucous membranes of the stomach were made to undergo self-digestion by dissolving them in warm acidulated water and concentrating the clarified liquid in vacuo and then drying on plates of glass.

In this manner a readily soluble pepsin was produced, but it was soon learned

that what had been gained in solubility was lost in permanency. The peptone which was formed during the digestion of the membranes was retained in the finished product, to which it imparted a highly hygroscopic and easily putrescible character.

To remedy this serious objection and yet retain the desirable quality of solubility, the proportion of peptone was reduced either by partially preventing its formation during the preliminary treatment, or by dialysis through parchment paper, peptone being a crystalloid and of greater diffusibility than pepsin.

These improvements in the manufacture of peptone-pepsins advanced the digestive power from 1000 to 2000, but they did not completely overcome the difficulty, as a considerable quantity of peptone still remained associated with the ferment and quite sufficient to cause such pepsins to assume a sticky or viscous condition when exposed to a moist atmosphere.

It is evident from what I have said that a truly ideal pepsin is one in which the causes of putrefaction, hygroscopicity and insolubility do not exist. Chief among these causes are peptone and mucus, both inactive as digestive agents, but usually present in a greater or less degree in commercial pepsins as objectionable contaminations, the former lending a hygroscopic and the latter an insoluble character to the pepsin containing them.

By the use of sodium sulphate at a moderately high temperature I have succeeded in separating pepsin from peptone without injury to the ferment. This discovery, coupled with certain methods of purification which can be found described in the *American Journal of Pharmacy*, 1891, p. 423, has made it possible to manufacture a permanent and soluble pepsin, substantially free from peptone and mucus, and possessing the extraordinary power of digesting 6000 times its weight of coagulated egg-albumen by the usual six hour test.

This brand of pepsin is known in commerce as Webber-Pepsin, S. & D., and although its greater activity makes it intrinsically more valuable than any other similar product on the market, its manufacturers, Messrs. Sharp & Dohme, of Baltimore, Md., offer it at the usual price that is placed upon a high grade pepsin. The Webber process makes it practicable to produce pepsin of much greater power than 1 to 6000, and its manufacturers are prepared at any time to increase the digestive strength of Webber-pepsin should the medical profession indicate a preference for a yet higher standard.

As a matter of scientific interest I have in my hand a small specimen of pepsin which has been still further purified so that one grain is capable of dissolving nearly four pounds of coagulated egg-albumen. I place its digestive strength at 1:25000 and will pass it around for your inspection and subsequent examination should any of the members so desire.

When we stop and consider the remarkable activity of this specimen, and the fact that there is still present inert matter associated with the pure ferment, the question naturally arises: What is the contaminating substance? To me it appears to be not true peptone, but, chiefly, albuminoid matter, which is not

hygroscopic, and if it were possible to separate this substance entirely without impairment of the ferment proper, the digestive power might possibly be increased to 100,000. Assuming that such a ratio of pepsin to albumen marks the limit of power for the pure digestive principle of the gastric juice, then a 6000 pepsin contains but 6 per cent. of true pepsin and a 1000 pepsin but one per cent.

In the case of the Webber-Pepsin the obnoxious contaminations, such as true peptone and mucus, have been practically eliminated, leaving the pure ferment primarily associated with a permanent and unobjectionable albuminoid body and, secondarily, with a small proportion of the precipitant, sodium sulphate, which is readily soluble, permanent even in moist air, absolutely harmless when administered and not in the least affecting the activity or proteolytic power of the pepsin, thus making its presence as a partial diluent most desirable and eminently preferable to the easily putrescible peptone which is largely the diluent of peptone-pepsins.

Pepsins made by the Scheffer process necessarily contain more or less sodium chloride which, like sodium sulphate, is a desirable component; the sulphate, however, being preferable to the chloride, as the latter is more susceptible to the influences of moisture.

Before closing my remarks I desire to briefly outline the method I pursue in determining the proteolytic value of soluble pepsins.

I first prepare an acidulated water containing 2 per cent HCl by mixing 5.5 c.c. (6.38 grammes) of hydrochloric acid (sp. gr., 1.16) with sufficient distilled water to make 1 litre. In 100 c.c. of this acidulated water 100 milligrammes of a 6000 pepsin, or 150 milligrammes of a 4000, or 300 milligrammes of a 2000 pepsin are dissolved; 5 c.c. of such solutions will represent 5 milligrammes of a 6000, 7.5 milligrammes of a 4000, and 15 milligrammes of a 2000 pepsin, according to the supposed strength of the sample under examination.

The egg-albumen is prepared by immersing fresh eggs in boiling water for fifteen minutes, and after carefully separating the yolk, the white of the egg is passed through a brass or hair sieve having 30 meshes to the linear inch. Of this prepared albumen, 30 grammes are introduced into a one-pint wide-mouth bottle, and 295 c.c. of 0.2 per cent. hydrochloric acid water added. The bottle is well shaken and then placed in a water bath, the temperature of which is kept constant at 104°F. (40° C.). As soon as the contents of the bottle have reached the temperature mentioned, 5 c.c. of the pepsin solution are added and the digestion allowed to proceed for six hours, the mixture being gently agitated by a rotary motion every ten minutes. At the expiration of the time stated, but a slight trace of albumen should remain undissolved.

And now, gentlemen, before resuming my seat, having presented a brief review of the different phases through which pepsin has passed since its introduction into pharmacy, I desire to express my thanks for the courtesy which you have been pleased to extend to me this evening.

A SHORT STUDY IN CLINICAL OBSTETRICS.*

BY FREDERICK DUNNING, M. D. (JEFFERSON, '92), OF EASTON, MD.

Mr. President and Fellow Physicians:—Permit me to preface my remarks by praying you to be charitable in your criticism of the first paper read by me before such an array of eminent medical gentlemen. Under the heading "a short study in clinical obstetrics," I shall report some cases attended during a short time as interne to the obstetrical ward of the Jefferson Medical College Hospital. The case of induction of premature labor I report not as one of great interest to the specialist, but to show the necessity of a thorough knowledge of pelvimetry among the general practitioners.

The Induction of Premature Labor; Post-Partum Hæmorrhage; Recovery; Report of Case.—I. M., aged 20, colored, born in New Jersey. Father died nine years ago of pulmonary tuberculosis. Two brothers and two sisters died during infancy. Mother living and healthy.

Patient began menstruating at the age of thirteen, and has been very regular since that time. Last menstruation occurred June 18th, 1891.

During February, 1892, she was examined by Dr. E. P. Davis and the ward class. On palpation we found vertex presentation; position, left occipito-anterior.

By pelvimetry her measurements were found to be as follows:

Anterior superior spines, 22 c.m.; crests of the ilium, 23 c.m.; trochanters, 29 c.m. bandelocques, 17 c.m.; internal conjugate, 8 c.m.—thus showing a contracted pelvis.

During the second week in March, 1892, Dr. Davis made a second examination and found that the head readily became engaged in the superior strait. On March 18th no symptoms of labor had begun, and considering the condition of the pelvis, it was the opinion of Dr. Davis that induction of labor was indicated. After reaching this conclusion he ordered the writer to have two flexible bougies put in a thoroughly antiseptic condition. On March 19th, at 12 o'clock noon, a douche of bichloride of mercury was given (one to five thousand), then Dr. Davis cautiously inserted one of the bougies between the membranes and the uterine wall. At 2 P. M. the writer was called, and on examination of the patient he found that the membranes were ruptured and the patient was having slight pains. At 5 P. M. another bougie was inserted. At 7 P. M. the pains became more severe and were more frequent. At 12 midnight the bougies were forced out and severe pains in the back and abdomen occurred with intermissions of five minutes. At 1 A. M., March 20th, a vaginal examination was made; the os was found to be about the size of half a dollar. The pain increased in sever-

*A paper read at the Semi-Annual meeting of the Medical and Chirurgical Faculty of Maryland, held at Easton, Md., November 16th and 17th, 1892.

NOTE.—My thanks are due to W.M.L. Coplin, M. D., Professor of Hygiene and Demonstrator of Pathology at the Jefferson Medical College, Philadelphia, for assistance in the bacteriology and for the use of his laboratory, which was placed at my disposal.

ity and Dr. Davis was sent for at 1.30 A. M. The second stage of the labor was completed without difficulty, at 4 A. M., the completion of the third stage soon following. One drachm of fluid extract of ergot was administered. At 5.30 A. M. I was called by the nurse, who stated that the patient had been bleeding profusely and was cold. On examination I found the bed saturated with blood, the patient's pulse rapid and weak. She was in a semi-comatose condition and a cold, clammy perspiration covered her forehead. The uterus was flabby and distended. I immediately removed the pillows from under the head, raised the foot of the bed and with both hands externally made firm pressure on the uterus. Towels were rolled and placed on either side and above the uterus as pads, and a binder was placed over these to keep them in place. The patient promptly responded to this treatment. The mother and child are now (March 22nd) in an excellent condition.

The fœtal measurements were as follows: occipito-frontal, 11 c.m.; biparietal, 9 c.m.; sub-occipito bregmatic, 8.75 c.m.; maximum, 12.75. c.m.

Remarks.—To review the condition which may call for or demand the induction of premature labor would only be to repeat what is already incorporated within the standard text-books on the subject of obstetrics. This case is reported, therefore, not as an extraordinary event, but merely to put on record the facts to which I have briefly alluded. The occurrence of post-partum hæmorrhage in induced labor is an accident for which we may look in a certain percentage of cases. There is, however, no cause for great alarm, provided we are thoroughly prepared to meet it. The writer has observed several cases of hæmorrhage after labor, and cannot say that the one herein reported differs in any essential point from those cases following natural labor.

The Relation Existing between Maternal Syphilis and Infection of the Infant. Report of Case.—Mrs. F., colored, age 30. Family history good; married, and the mother of three children previous to this one, all of which are affected with a scrofulous eruption.

After a normal pregnancy her last labor began March 12th, 1891, the delivery of the child being effected without difficulty at 11 P. M. the same date, by a senior student of the Jefferson Medical College. After waiting for the placenta until 8 o'clock the following morning, Dr. E. P. Davis was sent for, but he being in attendance on another case, the message was forwarded to the writer, who reached the patient at 9 A. M., March 13th, 1891. On examination, I found the placenta partially in the vagina and the uterus totally inactive. Ten grains of the sulphate of quinine was administered, and after waiting a short time for its effect, one hand was placed in the vagina and the placenta grasped; the other was placed over the uterus, which was stimulated by a gentle friction. Delivery of the placenta soon followed. The patient made an uninterrupted recovery. There was an abundance of milk, and no inflammatory symptoms manifested themselves in the mammary gland.

The patient denies any history of syphilis or other specific affection, but on

interrogating the husband, the writer ascertained that she had suffered from affections of the skin.

Seeing the condition of the other children, the writer concluded to investigate the condition of the milk, as to the presence or absence of bacteria. On March 19th, 1891, the breasts were sterilized and one ounce of milk was obtained by the use of a sterilized breast-pump; this was placed in a bottle which had previously been rendered sterile by heat. The milk thus obtained was taken to the laboratory of Dr. Coplin, and cover-glass spreads made. These were stained by Marchalko's method and mounted in Canada balsam. The microscope showed bacilli in large numbers, both singly and in chains; also colonies, linear and mixed. These organisms so closely resembled the bacillus of syphillis (Lustgarten) that the writer concluded to try the effect of mercury on their presence in the milk. Acting on this idea, the patient, although now well and going about, was ordered the prot-iodide of mercury in $\frac{1}{4}$ grain doses, three times a day. One week after the beginning of the above treatment the organisms had disappeared from the milk, and although repeated examinations were made at varying intervals until June 13th, 1892, the date of the last examination, none of the above bacilli could be found. At this date the child was as healthy as one could wish, and the father spoke of it as having less sickness than any other child he had. All the previous children suffered with "snuffles," this one did not. The writer called about the first of July, but the family had moved, and so the case was lost sight of.

Remarks.—The writer does not, in the present uncertain state of our knowledge concerning the asserted bacillus of syphillis, hold that he has diagnosticated a case by its presence as would have been possible in tuberculosis. It does, however, look probable that such is the case. The result of the treatment, both on the organism and health of the child, would indicate the possible relation of the two. Aside from the consideration of the possible infection of the child by imbibing milk from a syphilitic mother, we have to remember that the introduction of milk containing any bacteria imperils the health of the nursling. It has been satisfactorily proven that cow's milk may contain the bacillus tuberculosis, and it is presumptive that the human mammary gland may also furnish an excretory function in removing any organism from the circulation of the mother.

Causes for Rise of Temperature during the Puerperal State.—There are numerous theories as to the cause of fever in the lying-in woman. It is the purpose of the writer to briefly review these and suggest possibly some of the causes:

1st. In the first place, we may have fever due to the absorption of the inflammatory products. For the most part, this consists in the absorption of serum or inflammatory fibrin. This form of fever is what the surgeon considers as post-operation fever, and is not considered as due to infection. He believes it to be aseptic or fermentation fever. In the puerperal woman, as a result of the trauma to which the parts have been subjected, she must necessarily have an abundant exudate of inflammatory material, the absorption of which may give rise to fever;

as above stated. The application of this well-known and thoroughly established surgical theory would explain a large number of febrile conditions occurring immediately after labor, twelve or fourteen hours, and too early for us to presume that infection has had time to occur.

Another form of fever possibly in the puerperal state not due to sepsis is what is considered as intestinal toxæmia. We have developed normally within the intestines a large number of animal alkaloids. These are leucomaines or extractive, and if produced in excess or retained within the system may alter the thermo-genic or thermo-litic functions of the central nerve system. As yet none of these materials have been satisfactorily isolated. The possibility of their occurrence is admitted by all writers and put forward by several as a not uncommon cause of fever. Besides a production of leucomaines and extractives we have true bacteriological alkaloids, in any number depending upon the presence of certain organisms, the exact nature of which we do not as yet thoroughly understand. It is not improbable that many of the post-prandial headaches and indistinct nervous symptoms, such as malaria, that we are all are subject to after hearty meals or improper food, may be due to one or more of the forms of intestinal toxæmia.

3rd, Sapræmia. There is another condition which is no doubt very common. It is probably the condition which is most frequently considered as aborted septicæmia, but which is indeed sapræmia. This condition is such as would occur by infection of clots within the uterus; these breaking down through the activity of micro-organisms, bacteriological ferments are absorbed by the lymphatics of the uterus or possibly taken up by the veins, and when introduced into the system give rise to marked thermal changes. This is hardly septicæmia, as we will consider later. It is the absorption of microbic products developed outside of the living organism in dead tissue. Thus, while the intra-uterine clot is in one sense within the organism, in the true sense it is still on the outside, and any ferments produced in it are ferments produced in dead tissue outside of the healthy structure. These causes are to be sharply differentiated from septicæmia. A single antiseptic douche will remove all the infected tissue and the symptoms will not recur. This is quite a different picture from what we will see in true septicæmia, of which we will now speak.

Septicæmia. In septicæmia we probably have it beginning as sapræmia, that is, we probably have infection of wound surface or intra-uterine clot preceding the general infection of the organism. The microbes, either of suppuration or other forms, the exact nature of which have not been made out, find an entrance into the circulation, possibly through the uterine sinuses, possibly through the abraded surfaces—maybe both—and once in the circulation they produce other products which lead to the development of fever and the accompanying conditions which we recognize as septicæmia. It will thus be seen that septicæmia differs from sapræmia in that micro-organisms are circulating in the blood and develop throughout the tissues of the body, in the former, while in the latter their growth is only maintained outside of the vital structures in some dead mass, as a

clot or a slough. The presence of bacteria in the circulation and in the blood-clots within the organism prevents the organization of the thrombi present in the uterine sinuses upon which we must depend for their occlusion.

4th. Pyæmia is probably septicæmia plus the secondary infection, or possibly a mixed infection with some other organism than those present in ordinary septicæmia as we understand it.

Society Reports.

TRANSACTIONS OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

SECOND ANNUAL MEETING, HELD IN NEW YORK, OCTOBER 4, 5 AND 6, 1892.
THIRD DAY, OCTOBER 6, EVENING SESSION.

THE PHYSIOLOGICAL EFFECTS OF THE MAGNETIC ELECTRIC CURRENT OF REGULAR VARIATION, or what is termed the sinusoidal current, by Dr. Kellogg.

The author said that his attention had first been directed to the subject nine years ago, by noticing some peculiar effects obtained in the telephone exchanges from the currents generated by the magnetic electric machines used there for ringing bells. By regulating a properly constructed sinusoidal apparatus, a current of great intensity may be passed through the body without producing pain, contraction, or chemical action. By gradually increasing the frequency of the alternations, energetic muscular contractions may be induced, but they are infinitely less painful for the same intensity than are those produced by other currents. This current also possesses more penetrating power. Thus, with one electrode between the feet, and the other grasped in the hands, both limbs may be thrown into the most violent muscular contraction, without the subject experiencing the slightest prickling sensation.

The author then described the method of using this most efficient current in the treatment of obstinate constipation, and deficient mobility of the stomach. In the treatment of the former condition, one electrode is placed in the rectum, and the other on the abdomen, or better still, over the cervical region. This current is a very valuable aid in producing passive motion in connection with the rest cure, for such powerful muscular contractions may be excited as to cause the patient to shake the table on which he is lying, and yet he experiences no sensation other than motion. It produces the happiest impression on the patient. The current also possesses decided analgesic properties, when generated by a very rapidly moving machine, the dose being properly regulated by a rheostat. The alternating current is also a truly sinusoidal current, although the rate of interuption is so great that the curves are too small to be readily studied. After referring to the effect of this current on the special senses, the author described his method of obtaining tracings from the different currents for the purpose of study, and exhibited a number of such tracings. In concluding he said he did not wish to claim priority over D'Arsonval, for this investigator deserves the credit which has been accorded to him; he only wished to place on record the fact that he noticed the peculiar effect of this current, and had made use of it for the past nine years.

Mr. Carty spoke of the importance of studying these currents in this way by the graphic method.

The President spoke of the observations which he had made and published ten years ago on the oscillatory current derived from the Franklinic machine by the aid of his own discovery of attaching condensers and then regulating the rate of oscillation and strength of condenser discharged by the aid of a graduated air gap and spark between the discharging rods. It was by this same means that Nicola Tesla many years later had obtained these remarkable effects of alternating currents which had made him famous the world over—only in place of a Holtz machine, Tesla had employed a powerful and especially constructed dynamo-machine. He, the president, had at the time denominated the current thus specially and novelly obtained from the Holtz machine, the "static induced current" in want of a better name. He had at once noted the peculiarity of its physiological effect, which was to cause widely extended muscular contraction with comparatively little pain and to produce at the same time an anæsthetic and analgesic condition. After much experience with this current, both at his clinic and in private practice, he was able to say that no other current with which he was familiar produced such remarkable changes in the general nutrition of the patient.

It was along this line, that of promoting the general nutrition of the patient, that some most important work was now being prosecuted in France by D'Arsonval, Gautier and Larat. D'Arsonval had provided the apparatus and laboratory experiments of highest scientific value, while Gautier and Larat had introduced the sinusoidal current into medical practice. The special effects claimed for this current seemed most reasonable and its introduction into electrotherapeutic procedures is in reality a most notable event. At present, the usefulness of most of our applications is greatly limited by the pain produced. The new sinusoidal current excluded the objectionable feature of the Volta-induction apparatus and furnished new elements of its own of highest importance in the treatment of disease.

ELECTRO-THERAPEUTICS AND THE SYSTEMIC TREATMENT OF MORBID GROWTH, by Dr. John A. Cutter, of New York.

The author narrated the histories of several cases of morbid growths of the breast, and one of abdominal fibroid, which were cured chiefly by a beef diet. He quoted Ephraim Cutter's definition of cancer, as "tissues under mob-law," and summarized the treatment as consisting of (1) the use of a beef diet; (2) stopping every loss of nerve force; and (3) in keeping the specific gravity of the urine below 1015 or 1020. His conclusion was that "either some cases of cancer are cured by electricity and sustaining treatment, or eminent surgeons do not know what cancer is."

LACERATIONS OF THE CERVIX UTERI, AND THEIR TREATMENT, by Dr. F. von Raitz, of New York.

This paper was based on 73 cases which he had classified according to the depth of the laceration. The symptoms bear a definite relation to the depth of the tear. The treatment, he said, should be founded on the pathology of the disease, and, as a rule, the lacerations themselves do not require treatment; only when they are extensive is trachelorrhaphy demanded. The ordinary method of application was to use a large negative electrode over the abdomen and the positive pole in the vagina, the cervix being protected by a piece of absorbent cotton. A current of 100 milliamperes was employed for about five minutes, and followed by the faradic current for five minutes more. The electrical application was then discontinued, and a local astringent application was made. Where there was much hyperplasia, the negative pole was first employed for its softening effect; afterwards the pos-

itive pole and an astringent, two treatments being given each week. Here weak currents of long duration are best. Where trachelorrhaphy is required, a preparatory course of treatment with electricity is of great benefit.

Dr. Goelet thought Emmet's operation was easier and quicker in its results, and emphasized the fact that electricity was useful only in removing the morbid condition resulting from the laceration. This it would unquestionably do.

Dr. Gunning was in doubt as to how much of the result should be attributed to the electricity, and how much to other measures.

Dr. von Raitz replied that when he had omitted the electricity he had found that much more time was consumed in obtaining the result.

THE CONSTANT CURRENT IN GLAUCOMA AND CATARACT, by Dr. S. T. Anderson, of Bloomington, Ill.

Dr. Anderson reported three cases treated by means of a special battery which was worn over the eye. The patients had been examined before, during and after treatment by a competent oculist. The speaker had no faith in the method at the beginning.

The discussion hinged upon the construction and action of the battery, and Mr. Carty and one or two other electrical experts were asked to explain this point. They reported that the battery was short-circuited through its metallic case, and therefore no current which it might generate could be conducted into the tissues upon which it was placed.

Dr. Nunn said that "suggestion" could be excluded, as the author had the optical measurements on record, but it was possible that some of the benefit derived might be due to pressure.

Dr. Anderson said that he had no explanation to offer, but he could vouch for the trustworthiness of the parties who had along with himself observed and reported on the cases.

The incoming President, Dr. A. H. Goelet, of New York, was then presented to the Association, and after Dr. Nunn had on behalf of the Association expressed its appreciation of the services rendered by the retiring President, Dr. Morton, the Association adjourned.

GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

NOVEMBER MEETING.

The President, Dr. B. B. Browne, in the chair.

Dr. George H. Rohe read a paper entitled GYNÆCOLOGICAL WORK AMONG THE INSANE.

The subject was treated under three heads: 1. Is it necessary? 2. Is it practicable? 3. What are the results?

To show the necessity of the work it was stated that of thirty-five insane women examined, twenty-six, or 74.3 per cent., showed some evidences of pelvic disease or abnormality. The lesions found were mostly tears of the perineum or cervix, uterine displacements with adhesions, adhesion of the tubes and ovaries, cystic ovaries, parovarian cysts, etc.

Dr. Rohe expressed the belief that a careful examination by a competent gynæcologist would show that at least fifty per cent. of all insane women had some form of pelvic disease. This large percentage of diseased pelvic organs among the insane certainly indicated the necessity for gynæcological treatment among this class of patients.

That this work can be successfully carried out among insane women is evidenced by the report of eighteen cases of abdominal section with removal of the tubes and ovaries. The patients were affected with the various clinical forms of mental disturbances: melancholia, mania, periodic mania, hysterical mania, puerperal insanity, epileptic insanity and hystero-epilepsy.

The duration of the insanity in the various cases was from one month to eleven years. In all but one case the insanity had lasted over a year, and in very few were there any good prospects of recovery under the usual management.

At the date of reading the paper, three of those operated upon had been discharged recovered, and in ten there had been decided improvement in physical and mental symptoms. Two had died after the operation, one from sepsis, and one in *status epilepticus*.

These results are believed by Dr. Rohe to justify the prosecution of gynæcological work among the insane. The plea is made that the insane woman is as much entitled to relief from physical ills as is her sane sister. No argument beyond the recital of the facts should be necessary to enforce this view.

Dr. William P. Chunn: I have operated upon two cases of hystero-epilepsy; in both I removed the ovaries. Both recovered from the operation and both were improved in general health. I would be very loath to operate upon any case where examination failed to discover to the touch appreciable disease. It is well to differentiate between epilepsy and hysteria. The former is in my opinion incurable. If a woman is made peevish, irascible and melancholy or unreasonable from pain or the dread of pain, she may be called nervous or hysterical, but this is not epilepsy. Personally I would not take out the ovaries or tubes for hysteria or epilepsy unless disease could be demonstrated before or at the time of operation.

Dr. Wilmer Brinton: I have seen three cases of puerperal insanity in private practice; they were treated for a while at home, but they became so violent the families were compelled to send them to an institution for the insane. All three died there, and their deaths occurred within ninety days after delivery. I believe that the greater number of cases of puerperal insanity result from septic inoculation at the time of delivery, or from some lesions of the genital tracts.

Dr. Thomas Opie: Dr. Chunn has remarked upon the fact that in several of Professor Rohe's cases there was no pathological state of the ovaries discovered and that therefore the operation for their removal was contraindicated. There are occasionally met with cases when our manual explorations reveal no physical change in these organs, and yet their functioning is disordered in the most positive way. The following case will serve to illustrate my point:

M. R., age 31, single. Menstruation began at 13, and continued regularly and without pain until sometime between 16 and 18 years of age, when she first manifested a condition of delirium at her monthly periods. Her abnormal menstruation was persistent. When between 25 and 26 her menstruation was accompanied by still more pronounced disturbance of this function and greater mental alienation in the way of inability to concentrate her thoughts and a confusion of ideas. When at the age of 28 there was observed at her periods a twitching of the lower limbs, a short time before the appearance of her flow. This lasted during its continuation and for a week afterwards. With each recurrence these attacks increased in severity, gradually involving the upper extremities in clonic spasms. A year prior to operation she began to lose consciousness during the attacks. Occasionally between her periods she had muscular twitching, which

always passed off in a few hours. Until this time the invalid had been able to attend to light duties in connection with her home. For eight months prior to operation, she was totally disqualified for all duties, mental and physical; indeed, was bed-ridden.

Upon admission to the hospital, May 18th, she was in a most debilitated and anæmic state physically, associated with well-marked mental aberration. Her look was confused, there was momentary stupor, she became convulsed, her head was thrown back, muscles were rigid, pupils contracted, skin moist, urinary secretions scanty, respiration increased, temperature normal. When the attack was over she stated, on being interrogated, that she remembered nothing about the attack.

An oophorectomy was performed May 21st. The ovaries were found to be relatively small and perfectly normal. June 9th, no recurrence of spasms, her mind clear and active. June 27th, patient has entirely recovered from operation and has no neurotic symptoms. Five months have elapsed since the removal of the ovaries. She is restored mentally and physically to a state of health.

There was no neurotic family history in this case. Her troubles began coincidentally with her earliest menstruation. At first they simulated the aura. The attacks accompanied her ovulation for 18 years, growing year by year worse, until she was upon the brink of ruin, both as to mind and body.

The ovaries, on removal, gave all the appearances of being normal.

Dr. J. Whitridge Williams: I have listened with interest to the conservative views expressed by Dr. Ashby regarding the removal of the uterine appendages for physical disorders, and wish to add my voice to his in condemning the indiscriminate castration of women under all sorts of pretexts. Unless we are able to diagnose a pathological lesion of the tube and ovaries, we should not think of attempting to remove them either for the relief of pain or as an experimental measure in physical disorders; for it is only when they present a marked pathological lesion that we can be at all sure of our results after operation, and we are liable to be accused of reckless surgery if we remove apparently normal organs purely for the cure of some evil of whose cause we are yet in ignorance.

Recent work on the nerves of the ovary gives us more of a basis upon which to base the doctrine of reflex ovarian disturbances; for von Herff has shown that the ovary contains nerves, which supply all parts of the organ. These are so abundant that he states that they not only are present in large quantities, but that they may be said to compose a considerable portion of the bulk of the ovary.

613 Park Ave. WILLIAM S. GARDNER, M. D., Secretary.

TO AVOID INCONTINENCE OF FECES AFTER CUTTING FOR FISTULA.

The only serious complication following the operation for fistula-in-ano is incontinence of feces, and this is fortunately a rare complication. It may be guarded against by care in dividing the sphincter muscle only at one point, and by seeing that the division of the muscle is not an oblique one. When incontinence exists, it may be relieved in many cases by excision of the cicatrix in the sphincter muscle and by suturing the freshened ends of the muscle together by catgut sutures, or by applying a point of Paquelin's cautery to the cicatrix or to several points of the mucous membrane and skin of the anal margin.—Dr. Wharton, before Philadelphia County Medical Society.

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BALTIMORE, FEBRUARY 4, 1893.

Editorial.

HOW NOT TO ADMINISTER PEPSIN.

In a preceding column we present to our readers from the original manuscript a paper by Mr. Webber, a German translation of which has appeared already, we believe, in the *Deutsch-Amerikanische Apotheker Zeitung*, December 15, 1892, of New York.

We regard the science of pharmacy and medical chemistry as a department of the great medical calling, without which modern therapeutics could not exist. Therefore, while striving to keep our literary columns free from business advertisements, we are always ready, as far as space will permit, to welcome such articles as Mr. Webber's, which embody the work of an enthusiastic scientific investigator who publishes his methods freely to the profession.

We are requested to utter a word of caution to our readers in regard to wrong ways of administering pepsin.

The unfavorable results reported may be ascribed partly to faulty diagnosis; for the highest ends cannot be secured unless the physician catches the idea of the artist, who, in a reply to a question, "What do you mix your paints with?" replied "Brains, sir, brains."

Failure is partly due also in some cases to the use of inferior brands of the drug and to the use of too small doses.

It is important, however, to know that pepsin is one of the most sensitive remedies in the pharmacopœia.

A friend writes: "Its range of incompatibles covers very nearly the whole materia medica. Metallic salts as a rule diminish its proteolytic action quite appreciably. Most alkaloidal salts, as well as the alkalies and alkaline carbonates, when used with pepsin are inhibitors of digestion. Antiseptics rank high as retarders of its action. Antipyrin and antifebrin are contraindicated. The best

rule to follow is to prescribe pepsin alone, or with some substance known not to retard its activities. Sugar of milk, glycerin, dilute acids, and very weak alcoholic solutions are the best vehicles."

NOTE.

Last year we noted with regret the destruction by fire of the fine new sanitarium at Asheville, N. C.

Feeling that it is but right that journals which have notified the public of Dr. von Ruck's loss should give notice when he is in condition to receive patients again, we have solicited from Dr. von Ruck the brief account of his re-opening given in our column of "Items."

Medical Progress.

PRECAUTIONS IN POST-NASAL TREATMENT.

In summing up his conclusions at the end of an instructive article in the *Lancet*, of December 17, 1892, Dr. Barr says:

I shall now state as concisely as possible the precautions which to my mind should be kept in view when treating the nasal passages and naso-pharynx, in order to avoid or diminish the risk of exciting disease in the middle ear. 1. Patients before using the nasal syringe, Weber's douche or the hand douche, should be carefully instructed by the surgeon in their proper and safe use. 2. Previous to injecting fluids by the syringe or Weber's douche into the nose, or prescribing such, the nasal passages should be carefully examined, and if one should be found obstructed the fluid should be injected *into the obstructed passage*. 3. The nozzle of the syringe should not tightly close the nostril and during the injection of the fluid the stream should be frequently interrupted. 4. If a syringe is employed, too great force must not be used, especially if there be resistance to the flow of the fluid from one nostril to the other; if Weber's douche is employed the fall must not be too great—not more than two feet. 5. The fluid injected should always be comfortably warmed—say 80° to 90°F.—and it should hold in solution a saline, such as a one per cent. solution of common salt or bicarbonate of soda, while in ozæna or other bacterial diseases a definte antiseptic should be employed. 6. The act of swallowing must carefully be avoided during the douche; this is aided by breathing through the mouth. Eitelberg suggests that the patient should protrude the tongue so as effectually to prevent the act of swallowing. 7. In case of infants or very young children, or in adults whose Eustachian tubes are abnormally permeable, the syringe or Weber's douche should not be employed. The liquid should in these cases be poured into the nasal passages with a spoon or other suitable appliance while the patient (if old enough) should sound the vowel "a." 8. The patient should not blow his nose or, if possible, sneeze for at least fifteen minutes after; he should be instructed that in the event of the liquid entering the ear, he must swallow several times with the nostrils closed. 9. After operations on the nose or naso-pharynx, or the use of corrosive substances which may produce swelling or obstruction, the syringe should be avoided or used with great caution, for a few days, during which the patient should be careful to avoid exposure to cold or septic influences. 10. In operations or cauterization great care should be taken to secure cleanli-

ness and an aseptic condition of the instruments or appliances used. If the finger-nail is employed to scrape away vegetations there is obviously special need for precautions in these directions.

OVARIOTOMY DURING PREGNANCY.

From a study of 135 cases in which pregnancy was complicated by the existence of a tumor of the ovary, and in almost all of which ovariotomy was performed, Dsirne (*Archiv f. Gynäkologie*, B. xlii, H. 3, p. 415) concludes that such a complication is always to be considered as a serious matter, demanding, with but rare exception, the extirpation of the tumor. The further advanced the pregnancy, the more dangerous the condition, both for mother and fœtus. Puncture of an ovarian cystoma and the artificial interruption of pregnancy are to be considered only as emergency procedures. Ovariotomy yields the best results for the mother if performed in the second, third, or fourth months of pregnancy; for the fœtus if performed in the third or fourth month. If for any reason early ovariotomy is not possible, the operation should be performed subsequently, as good results are to be expected.—*Medical News.*

THE "SUN" CHOLERA CURE.

Take equal parts of tincture of opium, tincture of rhubarb, tincture of cayenne, spirits of camphor, essence of peppermint.

Mix well together. Dose: fifteen to thirty drops in water; to be repeated in fifteen or twenty minutes if necessary.

This is the original formula for the *Sun* cholera cure. It was given to the *Sun* in the "cholera year" 1849 by George W. Busteed, then and now a practising pharmacist in this city. It was published daily in the *Sun* during the summer of that year. It was published at intervals for several years, and again daily during the "cholera years," 1855 and 1866, and has been printed in the *Sun* probably 1,000 times since it first appeared.

The *Sun* cholera cure has been adopted into the United States Pharmacopœia, and is a medicine approved and valued by every medical man in the country.—*American Analyst*, October 1, 1892.

SALT AS A SWEETENER OF SUGAR.

Sugar and salt are sometimes held to be incompatible or antagonistic in their action on the organs of taste, but it is a common social experience that the addition of the slightest dash of salt adds flavor to sweet coffee, and sugar-cured hams have their own reputation, while meat and vegetables cooked "sour and sweet" are a favorite delicacy in Germany. Professor Zuntz, at the Physiological Society of Berlin, definitely explained the making of sugar sweeter by the addition of salt. From his experiments he finds that, if to a solution of sugar there be added a slight amount of salt and water, so weak that it excites no saline taste, the result is extra sweetening of the sugared water. The weakest of quinine solution is said also to produce similar results. The explanation given of the above seeming incongruity is, that the ever so feeble saltness or bitterness imparts an increased sensibility to the sensation of taste by the simultaneons stimuli, and hence an appreciation of additional sweetness.—*British Medical Journal.*

PROTECTIVE INOCULATIONS AGAINST CHOLERA.

Klemperer (*Berlin. klin. Wochen.*, 1892, No. 39, p. 969) has succeeded in conferring upon man immunity to cholera by previous treatment with cultures of cholera-bacilli, three days old, that had been kept for two hours at a temperature of 158°. It was found that the blood-serum of persons treated with injections of from 0.1 to 1 c.cm. of such cultures had the property of conferring immunity

upon guinea-pigs. Some persons exhibit a natural immunity to cholera, but their blood-serum is protective in much less degree for guinea-pigs. The degree of immunity appeared to be dependent upon the intensity of the protective intoxication. The degree of immunity was also greater in inverse proportion to the degree of modification to which the cultures were subjected by exposure to heat. It was clearly demonstrated that moderate quantities of living cholera-bacilli can be injected subcutaneously without occasioning unpleasant symptoms.—*Medical News.*

ATHLETICS AND HEART DISEASE.

At a recent meeting of the Medical Society (*Lancet*, December 3rd, 1892), Dr. Collier, of Oxford, read a paper on Athletic Exercises as a Cause of Diseases of the Heart and Arteries. He desired to direct attention to the growing tendency on the part of young Englishmen to indulge in certain athletic exercises to an extent likely to prove harmful. He referred to the connection between oft repeated muscular effort and diseases of the heart, pointed out by Dr. Peacock, as observed in Cornish miners. In these men the symptoms began to develop at about the age of forty with slight dyspnœa and palpitation gradually increasing in severity. The pathological changes observed were dilatation and hypertrophy of the ventricles, with, in a certain proportion, incompetence of the aortic valves. He also referred to the researches of Dr. Clifford Allbutt contained in the St. George's Hospital Reports for 1870, in respect of the same causes operating in the forges, docks, and engineering works of Leeds. The lesions developed soon in the badly fed; the aortic lesions being the most pronounced. Dilatation of the aorta increased the work of the heart by rendering necessary the propulsion of a larger quantity of blood, and the distension increased until incompetence resulted. Other observations on the production of "irritable heart" in soldiers had appeared in the *American Journal of Medical Sciences*, by Dr. DaCosta, of Philadelphia. This condition under forced marches frequently renders the men unfit for service. The same sequence of events had often been observed in animals, such as race horses, greyhounds and foxhounds. The evidence, then, was conclusive as to the effect of frequently repeated muscular exertion in the production of heart disease. Dr. Morgan's researches on the after-history of the oarsmen in the Oxford and Cambridge boat-races between the years1829 and 1869 comprised 251 out of 255 still living, and he came to the conclusion that the majority were rather benefited than otherwise by their exertions. It must, however, be borne in mind that these researches bore upon picked and carefully trained men. Dr. Collier admitted that the medical men of university cities were not likely to see much of the evil effects of such sports, inasmuch as they usually developed later in life. Boating, moreover, appeared to entail less risk than either running or cycling, and he insisted upon the fact that it was in the frequent repetition of severe muscular effort that the danger lay. The practice of riding against time is considered to be particularly pernicious, in support of which he quoted a number of instances of resulting circulatory lesions. He had had opportunities of observing symptoms pointing to dilatation of the right ventricle in rowing, running, and football adepts, but such symptoms occurred exclusively among badly-developed, narrow-chested, weakly men. The physiologically dilated and hypertrophied hearts of trained athletes underwent certain changes in the direction of atrophy of the muscular substance, which later on rendered the persons unable to cope with sudden extra strains. Dr. Sansom remarked that no symptoms of circulatory disturbance could be observed in many athletes, who nevertheless showed evidence of hypertrophy of the left ventricle. In coming to a conclusion whether

this hypertropny was to be regarded as physiological or pathological, the muscular development of the subject must be taken into consideration; when a large muscular system was associated with a large heart he was disposed to regard the condition as normal. He had, however, examined athletes who showed signs of dilatation of the right heart, while in others there was evidence of disturbance of cardiac innervation. He had seen a number of cases of tachycardia which were attributed to over-strain from racing on cycles against time. The condition might last for years, and structural disease of the heart had supervened. Under certain circumstances the delicate cardiac endothelium might develop a distinct endocarditis as the result of over-strain. Staff-Surgeon Preston, R. N., had pointed out the striking diminution in cases of disease of the heart and great vessels since the introduction of steam which had enabled the men to dispense with much of the heavy manipulation of sails and climbing of masts formerly necessary. During the ten years ending 1884 the ratio per 1000 of organic and functional diseases of the heart had fallen from 7.94 to 5.3; while the invalid ratio had been reduced from 3.9 to 2.9 per 1000. This was unaccompanied by a corresponding improvement in the land marines, thus showing that the reduction in the navy was due to labor-saving appliances. Syphilitic subjects were always the first to give way under exertion, and he believed that a man who had syphilis ought to abstain from athletics altogether. Brigade-Surgeon Hamilton said that aneurysm had become rarer among soldiers of late years, but since the introduction of quick manœuvres the "irritable heart" had become far more common; it had also been produced in the cavalry by riding without stirrups. He regarded a man with secondary syphilis as practically incapacitated from service. Functional disorganization of the heart was also materially contributed to by the use of tobacco and alcohol. The President did not take such a gloomy view as to the results of syphilis. For treatment he much preferred small doses of mercury, which was much superior to prolonged administration of iodide of potassium, which undoubtedly had a most depressing effect on the muscular system. Dr. Collier, in reply, said that the under-graduates of Oxford did not often expose themselves to the risk of contracting syphilis. He agreed that when athletic exercises were abandoned the retrograde changes that took place in the heart were liable to render that organ unable to cope with sudden strain.

THE IMPORTANCE OF OBSTRUCTION TO THE OUTFLOW OF URINE AS A CAUSE OF PUERPERAL ECLAMPSIA.

The following brief note concerning a necropsy which I performed a short time ago may be of value. The girl had died of double pleurisy with a little pneumonia, which had commenced suddenly with a rigor six days before her death. She was pregnant for the first time with a six-months' fœtus. Both ureters from the kidneys to the brim of the pelvis were dilated up to the size of the common iliac artery, while the kidneys were in a condition of slight hydronephrosis, with much congestion of their substance. No obstruction could be found within the canal of the ureters to account for this distension, and the whole condition strongly suggested that the ureters had been obstructed from without by the pressure of the pregnant uterus. The urine during her stay of four days in the hospital was highly albuminous and contained also a trace of deutero-albumose.—Dr. Hale, *Lancet.*

SINGULAR CASES OF POISONING BY GAS FROM A DISUSED MINE.

Emanations of carbonic acid gas from the earth, except it be from springs or in the neighborhood of volcanic districts, are comparatively rare, and the occurrence

reported in the papers on Tuesday must be considered somewhat unusual. It appears that in a mining village close to Wolverhampton two women died last week from the effects of a gas which is believed to have exuded from the neighboring disused coal mines into the cellars of the houses which they inhabited. The women who succumbed were found lying on the floor in convulsions, and some domestic animals also succumbed in the same house. The coroner's jury returned a verdict in the case of each of the two women of "Death from congestion of the lungs caused by inhalation of carbonic acid gas." It is difficult to account for this gas issuing from a disused coal mine. Coal has the remarkable property of storing or occluding inflammable gas (CH_4) within its substance, but this property does not extend to carbonic acid. Carbonic acid is of course familiar to the miner as the deadly afterdamp or chokedamp which follows an explosion, but in a disused mine the production of carbonic acid from this cause is out of the question. Whatever the origin of the gas may have been there can be but one conclusion as to the necessity of avoiding further disaster. The cellar floors of houses contiguous to coal mines should be lined with a cement which is impervious to gases, and the passages of mines that have been exhausted of their coal should never be allowed to get choked with waste material or rubbish.

TREATMENT OF THE HEART DISEASE OF INFLUENZA.

Writing in the *International Medical Magazine*, January, on the action of influenza poison on the heart, Drs. R. G. Curtin and E. W. Watson, of Philadelphia, give the following summary of the remedies found useful in its heart disturbances:

FOR SIMPLE HEART FAILURE.

First in importance was alcohol, after which citrate of caffeine and cactus grandiflora were well borne by the stomach. Ether and ammonia often were not. Citrate of caffeine must be given in small dose—one-grain doses are large enough; doses of three to five grains often produce headache and general nervous excitement. Digitalis and strophanthus were of use; atropia seemed to exercise a special influence for good. Nitro glycerin seemed to act favorably with aged persons and those having a gouty diathesis at any age. Strychnia is often of great service. It should be given in small tonic, not in heroic, doses. In anginose cases sometimes it was found useles. If the case is anæmic it is important to build up the general system by hypophosphites, iron, strychnia and quinine. Dyspepsia must be cured or relieved by peptonized food or by pepsin itself; in fact, great care must be exercised in feeding; meat often causes recurrences; a large amount of any food was generally badly managed, and meals towards evening were badly borne. Cod-liver-oil and malt benefited chronic cases.

INFREQUENT HEART.

Avoidance of mental worry or actual cares, or any attempt to work. Encouragement was of great use; the heart should not be much or often examined, nor any opinion unfavorable to its strength or soundness expressed. Stimulation (alcoholic) was vitally necessary.

Arsenic was valuable in anæmic cases, and one-drop doses of Fowler's solution before feeding seemed in some cases to increase retentive and digestive power. Bromide of ammonium quieted restlessness; sulphonal generally had a good effect, but was occasionally dreaded by the patient, but generally it was the most satisfactory hypnotic, often combined with bromides. Paraldehyde when well borne was useful.

The prognosis was hopeful, in almost every case, no matter how desperate it

seemed, except in the aged, with organic heart-disease, cardiac degeneration, and senile weakness. Recovery was the invariable rule in the young and robust.

Treatment of the anginal cases differed but little from that employed for weak hearts from other causes. Excessive stimulation and over-stimulation of the nerves was to be guarded against, for it sometimes aggravated the symptoms. The quieting effect of rest in bed, with the attending protection from cold, fatigue, and draughts, was of the greatest importance in the treatment of the anginose cases.

Medical Items.

Ten cents will be paid for each copy of the JOURNAL, of December 31st, 1892, if sent to this office.

The New York City Board of Health reports seventy-six deaths following laparotomy—more than half of the deaths due to all operations.

A movement is on foot in England looking to the creation of a department of public health with a responsible minister at its head.—*Med. Rec.*

Puerperal mastitis is often successfully aborted by prompt and energetic treatment with compresses steeped in hot water, in each quart of which one ounce of carbonate of ammonia has been dissolved.—*Ex.*

New York City has adopted an ordinance giving physicians holding a police permit the right of way in the streets with the right to cross processions as soon as possible when answering calls for their services. The permit is granted to any duly registered physician and is not transferable.—*North Carolina Medical Jour.*

If the stockings are soaked in a saturated solution of boric acid and allowed to dry, and be then worn, Professor Hare says that cases of *sweating of the feet* will often be cured, and in most cases, if not cured, the odor arising from the sweating feet will disappear.—*College and Clinical Record.*

The City Council of Baltimore appropriated, on January 23rd, $50,000 for the special labor required in clearing away the snow and ice which accumulated during the long cold spell, and for getting the streets and alleys into a healthful condition.

New York and Boston are doing more toward supplying public baths than most other cities. In Boston these baths, which are under charge of the Board of Health and are open during the four hot months of the year, were used 1,125,836 times during the past summer. Of the persons using them, 909,889 were men and boys, 216,947 women and girls.—*The Medical Age.*

Terrapins usually lie dormant in the winter, but this year have been frozen out of their holes by the extreme cold weather. It is remarkable, however, to see what a quantity of cold a terrapin can stand. During one of the coldest days this winter a dealer had placed some terrapins in a tub of water to thaw out and the water and terrapins froze into a solid block. The dealer thawed the terrapins out and they were not hurt in the least.—*Sun.*

Spontaneous hæmorrhages that are recurrent, and whose causes are not easily

discoverable, but are presumably due to diseased conditions of the liver, spleen or kidneys, are oftentimes speedily arrested by more or less revulsive treatment by means of blisters over either or all of these regions.—*North Carolina Medical Journal.*

A French surgeon is employing collodium in the treatment of erysipelas with marked success. He paints around the affected surfaces a broad band, and in cases of erysipelas of the extremities, he paints a streak about the breadth of two hands. Beyond this the disease never spreads, and improvement is noticeable usually on the second day. This method is also applicable to facial erysipelas.—*North Carolina Medical Jonrnal.*

A society is being formed which will have for its object the provision of occupation for epileptics who are capable of work, but debarred from finding employment by reason of their affliction. A movement in this direction was commenced a few years ago in connection with the Charity Organization Society, when Miss Nina Paget read a paper on the subject, but the matter was not then actively pursued. Early last year, however, the subject was again taken up (with the active sympathy of the Charity Organization Society) by the late Lady Taunton and by Miss Burdon-Sanderson, sister of the well-known professor of physiology at Oxford. The urgent need of provision being made in this direction had long forced itself upon the attention of these ladies, as a result of their experience in visiting the wards of the National Hospital in Queen-Square. They were continually meeting with cases showing the cruel hardship inflicted upon numbers of willing and capable men and women by the nature of the disease under which they were laboring.—*Lancet.*

Dr. Karl von Ruck has reopened the Winyah Sanitarium for diseases of the lungs and throat at Asheville, N. C., and the establishment is ready for the reception of patients. This building was occupied by Dr. von Ruck until about a year ago when he moved into his new establishment, which unfortunately was destroyed by fire last August. The "Winyah" is entirely remodeled and much improved, and the sanitary features have been thoroughly looked to. All plastered walls are now painted and varnished, and all floors painted for ready cleansing with soap and water. No carpets are in the house; instead of them there are rugs, which are daily taken up and dusted out of doors—all dusting in the house is done with damp or wet cloths, and no dust is thus raised or permitted to exist in any part. The establishment contains also a disinfecting room, where even large pieces of furniture and bedding can be exposed to the action of steam, either flowing or under pressure. The hydropathic facilities have also been increased and if the present investigations of Dr. von Ruck will prove it justifiable, an ozone inhalation room with the necessary generators will be put in. The system of hourly flushing of the house sewer has been adopted. The drinking water is taken from a living spring, which supplies the entire house.

Commenting editorially upon the Mayor's recent message, the Baltimore *Sun*, from whose columns we have gleaned several items this week, makes some very pointed but very sensible remarks. The *Sun* is just a little bit fatigued by the repetition of the statements that our city is or is not just as cheaply governed or as dirty as other American cities; and holds that "although Boston, which boasts a population and street mileage about equal

to that of Baltimore, reports an outlay for street-cleaning about double our own, it would be understating the fact to say that the streets of Boston are at least twice as clean—aye, four or five times as clean. In the kindest spirit we would suggest to the Mayor that what concerns our people most is not whether our streets are as well cleaned or as badly cleaned as those of another city—but are they cleaned at all? Are they cleaned sufficiently for the public comfort and the public health? And so with reference to everything else—it is not comparisons we want, but results." It is an omen of great promise that a city paper of such wide spread influence and high tone should so boldly contend for city sanitation of the best sort. The Mayor is to be thanked for his many excellent suggestions as to improvements, among them his contention that the chief street-cleaning authority should have supreme control over the men who do the cleaning. At present the cleaners are accountable only to the lesser bosses whose political prospects forbid the exaction of really serious service from his employees.

The Medical and Chirurgical Faculty held a special meeting this week and authorized the appointment of a special advisory committee of seven to aid the city health authorities to prevent an epidemic of cholera in Baltimore next summer, and co-operate with authorities in suppressing an epidemic should one occur. Dr. C. W. Chancellor, who was absent, sent a series of resolutions. He suggested that the government take steps to thoroughly inspect passengers, baggage and freight at European ports, and stated in detail a number of sanitary steps to be taken locally. The resolutions were referred to the advisory committee, which will be appointed in a few days. Dr. S. T. Earle, of the special committee, appointed to work for a building for disinfecting purposes and for a hospital for infectious diseases, reported that satisfactory progress had been made. The Faculty adopted a resolution offered by Dr. I. E. Atkinson, protesting against the withdrawal by Congress of the annual appropriation for the publication of the index catalogue of the surgeon-general's library. Thirteen volumes have been published and three remain to be published. Secretary Taneyhill was directed to write to Congressman Compton, of the appropriations committee, in favor of the appropriation of about $12,000.—*Sun.*

At the second annual meeting of the American Electro-Therapeutic Association, the following officers were elected for the ensuing year: President, Dr. Augustin L. Goelet, 531 West 57th Street, New York; First Vice-president, Dr. William F. Hutchinson, Providence, R. I.; Second Vice-president, Dr. W. F. Herdman, Ann Arbor, Michigan; Secretary, Dr. Margaret A. Cleaves, 68 Madison Avenue, New York; Treasurer, R. J. Nunn, 119 York Street, Savannah, Ga. The third annual meeting will be held in Chicago, on September 12th, 13th and 14th, 1893. A cordial invitation is extended to all members of the profession interested in electro-therapeutics. Arrangements for special rates on railways and at hotels are in progress. The committee of arrangements will be obliged, if those who intend being present at the meeting will send their names, the class and amount of accommodation required, titles of papers to be presented, applications for membership, etc., at as early a date as possible. Accommodation should be secured early on account of the crowded conditions of the hotels, because of the World's Fair. All communications should be addressed to the Secretary. The committee will be glad to furnish any information inregard to the meeting upon application. The committee of arrangements: S. C. Stanton, Secretary, 3537 Indiana Ave., Chicago; Franklin H. Martin, Chairman, Venetian Building, Chicago.

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GYNÆCOLOGICAL TECHNIQUE AS CARRIED OUT AT THE GYNECEAN HOSPITAL.*

BY J. M. BALDY, M. D.

It no uncommon thing to have physicians from all over the country, who are making a temporary stay in Philadelphia, and who are visiting the hospital with the object of seeing operations, question minutely as to the different points in the preparation, and not infrequently express surprise at the simplicity of these. In fact, it has often occurred to me that many of our visitors are more interested in the preparation than in the operation itself. To one who has the success of this class of work at heart, this seems to be a step in the right direction, as it has long since been recognized by the successful operators of the world, that more good results are obtained by mediocre operators, whose preparations have been most careful and systematic, than by their more brilliant colleagues who have been inclined to scoff at minutiæ and to depend upon their mechanical skill.

From time to time articles on this subject have appeared in medical print giving the most elaborate description of the preparation and the apparatus used,

*Read before the Philadelphia County Medical Society, December 28, 1892.

most of which are undoubedly excellent and well-fitted for the operating-room of a hospital, but which are unnecessarily cumbrous when one comes to apply them to private work. For this reason I have been encouraged to enter upon a detailed description of our work at the Gynecean Hospital, the application of which can readily be carried into private practice. The watchwords from the beginning to the end of an operation are *thoroughness* and *simplicity*.

The aim of all successful operators is the same, namely—the prevention of any septic matter entering into the field of operation. Different operators adopt different methods of accomplishing this object, but for success, the object and result must be the same, whatever the method adopted may be.

Antisepsis or *asepsis*, as fancy may dictate, the principle is the same. To be successful one must be surgically clean. For the proper accomplishment of this one must consider and treat: 1. The patient. 2. The operating-room and its paraphernalia, including tables, basins, pitchers, buckets, instruments, ligatures, sponges, dressings. 3. The operator, assistants, and nurses.

1. THE PATIENT.

The preparation of the patient should begin, when possible, at least twenty-four hours before the operation. The first steps are to regulate the diet and empty the gastro-intestinal tract. Free purgation is begun at once, preferably by the use of some saline. This is usually administered in the dose of a drachm of sulphate of magnesia, dissolved in water, each hour until the bowels begin to move. Usually five or six doses are sufficient to accomplish the object. The purgatives should be so administered that the action of the bowels ceases five or six hours before the time set for the operation. After beginning the administration of the purgative, the diet should be light and concentrated. If the operation is to be performed in the afternoon, the patient's supper on the day before consists of the ordinary house diet. From this time on nothing passes her lips, unless it be a glass of milk or a cup of bouillon at breakfast-time. Even water, except in small quantities, is withheld. These steps in the preparation can be carried out in the case of most patients, but in dealing with an unusually weak woman, considerable judgment must be used in their application. A hot bath is given, both the day before and the morning of the operation. If the patient is unable to be moved to the bathtub, the baths are given in bed. Prior to the final bath an enema of soapsuds and water and a vaginal douche of bichloride of mercury (1 to 3000) are given. Immediately on coming from the bath a fresh night-gown is put upon the patient and she is placed in a bed which has been especially prepared for her reception. After returning to bed the abdomen—the seat of the operation—is especially prepared. A nail-brush, soap and hot water are used freely and vigorously, special attention being paid to the umbilicus and pubic hairs. In but exceptional cases are the pubes shaved. The abdomen is then bathed with alcohol and turpentine and is finally protected until the time of the operation with a towel wrung out of bichloride solution.

When the patient is placed on the operating table the abdomen is well rubbed

with ether and bathed with alcohol by the operator as the final preparation, especial attention being paid to the pubic hairs and the umbilicus. The legs are wrapped in a blanket, which extends from the feet to the pubes; a second blanket is placed over the chest. All blankets, clothing, table, etc., about the patient from her chest to her feet are now covered with towels prepared for the purpose, the abdomen being left bare from the epigastrium to the pubes. Over all this is placed a piece of bichloride gauze, with a slit in it at the point of the incision.

2. THE OPERATING-ROOM AND ITS PARAPHERNALIA.

All tables used in the operating-room with the exception of the Krug frame for Trendelenburg's position, which is of galvanized iron, are made of wood, perfectly plain, and shellacked. The reason for this is twofold—first, because it is desirable in the preparation of the room that it should be emptied; this is rendered possible in the case of everything except the gas-fixture and the sink. Secondly, as there is an operating-room on each floor, it becomes necessary to frequently move the tables from one room to the other. When not in use, the windows in these rooms are always open. The walls of the room from floor to ceiling are of white tile, the window trimmings are of white marble, the floors are asphalt, the ceilings are plastered and heavily painted. In the preparation, the room is first stripped of all its furniture. The walls, ceiling and floor are washed down with the hose, and then mopped off with a cloth dipped in bichloride solution. As each article is brought into the room it is scrubbed with soap and water, rinsed off, mopped with bichloride solution, and placed in its proper position; the tables and benches are covered with sheets or towels specially prepared for this purpose.

All linen used in the operating-room has been laundried by itself. Distilled water is used throughout the operation.

Instruments.—After an operation the instruments are thoroughly scrubbed with soap and water, and are then passed through scalding water before being returned to the case. Prior to the operation they are boiled for twenty minutes in a weak soda solution. As few instruments as possible are used. In an ordinary operation, two needles, two ligature staffs, four hemostatic forceps, a knife, a needle-holder, and a pair of scissors are amply sufficient. These are taken, together with the tray on which they are placed for boiling, directly from the sterilizer, and put upon the table as the patient is brought into the room. In this way they are not handled from the time they are taken out of the sterilizer until they are to be used.

Ligatures.—Three varieties of ligatures are employed—silk, silkworm-gut, and catgut. A half-hour before the operation the silk is immersed in a bichloride solution (1 to 100); prior to being used it is washed in boiling water. The silkworm-gut is boiled with the instruments. The catgut is prepared by being immersed in ether for forty-eight hours, soaked for the same length of time in a 1 to 100 alcoholic solution of bichloride of mercury, after which itis put in a solu-

tion of two parts oil of juniper and one part alcohol. It is taken directly from the latter solution for use at the operation.

All sutures and ligatures used within the abdominal cavity are of silk (Chinese twist). Silkworm-gut is invariably used for closing the abdominal wound. Catgut is used principally in vaginal hysterectomy and plastic work.

Sponges.—New sponges are prepared by being thoroughly beaten, soaked for twenty-four hours in a weak solution (3 per cent.) of hydrochloric acid, after which they are soaked for twenty-four hours in a strong soda solution, and are finally placed in alcohol. Immediately after being used in an operation they are thoroughly washed in cold water, placed in a strong soda solution (practically a saturated solution) for twenty-four hours, at the end of which time they are removed, washed under the cold water spigot until all the soda is washed away, and are then immersed in a solution of sulphurous acid for twenty-four hours. They are taken directly from the acid solution, washed, and placed in commercial alcohol until used. Four sponges only are used at each operation.

Dressings.—The dressing of the abdominal wound consists in placing several strips of dry bichloride gauze over the incision, a cotton pad covered with gauze placed over this, and the whole held in place by a six-tailed bandage. Dressings are not disturbed for eight days. No iodoform or other powder is used. Stitch-hole abscesses are the rare exception.

Drainage-Tubes.—After being used, the glass drainage-tubes are soaked in strong soda solution for twenty-four hours, rinsed under the spigot, washed with turpentine and ether, and then boiled for twenty minutes, after which they are kept in commercial alcohol.

Rubber drainage-tube, whenever used, is soaked in bichloride solution, and washed in boiling water.

After an operation the drainage-tube is cleaned by the nurse every fifteen minutes or half-hour, as occasion requires. As the fluid discharged from the tube lessens in quantity, the intervals of cleaning are lengthened. Each time the tube is cleaned the nurse's hands are carefully prepared with soap and water and bichloride solution.

At and after each cleaning the syringe used to withdraw the tube contents is cleansed inside and out with hot water and bichloride solution, as are also the mouth of the tube and the rubber protecting it. Fresh bichloride cotton is placed over the entrance of the tube at each cleaning. The tube is removed as soon as the contents become clear and small in quantity. The edges of the opening left by the tube are drawn together by a strip of adhesive plaster, and the dressings replaced by fresh ones.

3. THE OPERATOR, ASSISTANT, AND NURSES.

Everybody who takes part in an operation, and is liable during its performance to handle any of the instruments or materials, is required to go through with the same preparation. All assistance is rendered by three nurses; the chief nurse assisting the operator directly, a second nurse attending to the sponges, and a

third nurse changing the waters. The preparation of operator and nurses is as follows: a hot soap bath, and clean linen clothing direct from the wash. The hands and arms are prepared by first carefully cleansing the nails with a penknife, a free use of hot water, soap, and nail-brush for twenty minutes, and rinsing in fresh water. They are then bathed in commercial alcohol, and are finally soaked in a bichloride solution (1 to 2000) for five minutes. The greatest danger-point of infection is, of course, under the nails, and time used in a most careful hand toilet is never misspent—is, in fact, absolutely essential to success.

A careful study of the cut, which represents one of the operating rooms as it appears prior to the introduction of the patient, will demonstrate the simplicity and thoroughness of all the preparations. There is not an article in the room which cannot be duplicated or easily substituted in almost any well-ordered household. Soap, water, nail-brush, and bichloride of mercury tablets are easily obtained, and as for the remainder it rests entirely with the surgeon and his nurse. With a little more time and trouble the poorest hovel can be turned into a good and safe operating-room, by adopting these rules, as I have been able to demonstrate time after time in my work in the slums of this great city. Of course, it means plenty of hard labor for both nurse and surgeon, but what nurse or surgeon who has once passed through the horrors of attendance at a death from septic peritonitis would not feel that the work before the operation was as nothing in comparison to that afterward.

The number of instruments, sponges, etc., may seem to many to be entirely inadequate for the purpose, but in many hundreds of operations we have found them amply sufficient; it is the rare exception that the recourse to the instrument-case is necessary. The fewer articles used, the fewer sources of possible infection and accident. A large number of instruments lying about are, in addition, a source of endless confusion and annoyance, and they require an extra assistant.

REPORT OF A CASE OF PNEUMONIA FOLLOWING MEASLES.*

BY H. S. HERMAN, M. D., OF HAGERSTOWN, MD.

After closing up my place of business here in the Court-House on Saturday evening, February 20th, 1892, on reaching my home at State Line, Pa., a message was there for me to come to see a sick child three miles north of the village. After my supper, jaded and worn by travels over bad roads, I reached the house and found the child, a frail, but intelligent looking lad—Elmer D., eight years old, lying in a large kitchen upon a trundle bed, surrounded by five smaller children, who were nearly all recovering from measles, one of whom still had the rash visible upon the skin.

Taking my seat by the side of the patient at 8 P. M., I found the pulse 130, temperature, 105°; respirations, 40 per minute, but apparently not labored. I inquired as to its previous history and elicited the following facts: For five weeks

*Read before the Washington County Medical Society, January 11th, 1893.

the child had been more or less sick, but not all the time confined to bed. For three weeks he had what the parents termed the "grip." During this time he was unable to attend school, but a short distance away. When he had, as they thought, recovered from the "grip," he was taken with an attack of measles, which "came out all over him" (as they stated) and evidently ran a regular course. But it was about two weeks before he recovered sufficiently to go out of doors.

On Wednesday evening, February 17th, the child ran down to the barn to call his father to supper; the evening was cold and rainy. That night the child took a chill, with vomiting, and became feverish, with loss of appetite. Thus he passed Thursday, Friday and Saturday, till I saw him for the first time that night. During all these attacks he had no medical attention (save domestic medication, taken from an old doctor-book—the bane of many a family). At this time there was dulness over the entire right lung anteriorly, the percussion note being very flat, and auscultation posteriorly revealed abundant crepitation over the lung of that side. The left lung did not appear to be implicated. I had no difficulty in making my diagnosis of pneumonia.

I put the child upon one-half drop doses of Norwood's pv. verat. viride and 3 grs. of phenacetine in capsule every two hours, alternately during the night, with milk as nourishment.

Sunday, February 21st, 2 P. M., pulse, 130; temperature, 104°; respirations, 40. There appeared to be a little improvement, but fearing the depressing effects of the coal-tar preparations, and feeling it was necessary to husband all the vital resources of my little patient, I discontinued the phenacetine, and continued the veratrum with 2 and 3 drop doses of fl. ext. jaborandi, every three hours, as long as the skin was hot and dry.

February 22nd, 7 P. m., pulse, 28; temperature, 103°; respirations, 36; skin dry; cough, tight. Spts. minderus added to expectorant (ipecac and senega.)

February 23rd, 7 P. M., pulse, 128; temperature, 104°; respiration, 50.

Owing to my official duties at court, it being criminal week, I could only see the patient in the evening once a day during the week.

I did not get to see the little patient until February 25th, 7 P. M.; pulse, 102°; respiration,—(watch broken); vitality low, weak, paler, nose and lips livid, deaf. Treatment: Tr. digitalis, carb. ammonia, whiskey and milk.

February 26th, 7 P. M., pulse, 140; temperature, 102⅘ ° respirations, 50; case growing desperate; moved child into a large and light front room, away from balance of family; unable to do so before; digitalis continued; whiskey ordered (½ ounce every two hours), diluted.

February 27th, 7 P. M., pulse, 140; temperature, 102⅕ °; respirations, 50; delirious all day. Whiskey had been discontinued in my absence, owing to the mother's prohibition propensities.

February 28th, Sunday, 9 P. M., pulse, 140; temperature, 101⅕ °; respirations, 50; delirium continuing still; ordered ½ ounce doses of whiskey every two

hours, diluted in water; treatment continued; case worse; picking at bed-clothes; subsultus, but no hiccough; deafness marked for several days; some lucid intervals. The temperature having declined within the last forty-eight hours, with pulse and respiration quickened, consolidation of the lung, and general weakness increasing, the first sound of the heart almost inaudible, with pulse so feeble as to be scarcely perceptible to the finger, I ordered digitalis and ammonia, with rigid doses of whiskey till 8 P. M. that night, when I gave 4 grains of hydrate of chloral to obtain rest to the patient for the night, and demanded that the stimuli and milk be given in specified doses and at regular intervals till I again could see the child. I left the little patient with many misgivings as to whether I would find the child living or dead in the next twenty-four hours. There was involuntary micturition during the day.

February 29th, 7 P. M., pulse, 128; temperature, 100°; respirations, 40; a slight diarrhœa during the day. There was now a small ray of hope which beamed through the rift in the dark cloud which overhung the child for days and nights. The diarrhœa was readily controlled by a few doses of subnitrate bismuth and Dover's powder.

March 1st. Did not see the child, but as the diarrhœa recurred, I sent it bismuth and Dover's powder, which effectually checked the drain from the bowels and soothed the child.

March 2nd, 7 P. M., pulse, 112; temperature, 100°; respirations, 36; improved.

March 5th, 7 P. M., pulse, 88; temperature, normal; respirations, 24; air beginning to enter vesicles in inferior portion of lung; percussion note becoming more resonant; convalescing. This was the last visit I made to see the patient.

On March 16th, whilst the child was about in the room, he was rather weak and emaciated. Ordered cod-liver oil in emulsion, along with generous and nutritious diet; appetite, good.

To make a short "resume" of the treatment as given by these plain facts taken from the clinical record of patient: From the incipiency of the treatment of the case, I sedulously avoided any perturbing or depressing treatment, except the phenacetine, which had been used only during the first day, with verat. viride a few days when pulse and temperature were very high; but as consolidation of the lung progressed, as indicated by the physical signs and increased rapidity of the respiration—almost panting—I substituted the carb. of ammonia (2 gr. doses) with whiskey (against parental objection), along with tr. digitalis (3 to 5 drops) to strengthen and steady the flagging heart, with poultices over the chest, with syrup of ipecac, senega or jaborandi, which generally kept the expectoration loose and brought up the brown and rusty sputa. I might here state, it is my opinion that the delirious condition of the little patient could have been averted, had I had the hearty co-operation of the parents in giving a sufficient amount of stimuli—for two days it was used in such a tentative manner that the child was upon the verge of the grave. It was only after an imperative demand, coupled

with the statement that if the stimuli were not given in more heroic doses, the child would speedily succumb to the disease, that they yielded; and the record shows improvement began from that date, the pulse and respiration beginning to show more power in their diminished frequency on the ninth day of treatment. The parents then became enthusiastic and it required some caution in the other direction, lest they should give too much. The supporting plan of treatment was continued until convalescence was well established, which continued up to about the second week in March, or about three weeks. At last account the little fellow was quite well.

231 W. Franklin Street.

Society Reports.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

STATED MEETING HELD THURSDAY, FEBRUARY 26, 1893.

The 751st regular meeting was called to order by the President, Dr. F. C. Bressler. The minutes of the previous meeting were read and approved.

The Corresponding Secretary reported that the present membership was 130; that the net increase for the last year was seven.

The Treasurer's accounts were audited by a committee consisting of Dr. D. W. Cathell and Dr. R. W. Mansfield and found correct.

The officers for 1893 were elected as nominated by the Executive Committee, as follows: President, Dr. J. Fussell Martenet; First Vice-president, Dr. E. Miller Reid; Second Vice-president, Dr. S. T. Earle; Recording and Reporting Secretary, Dr. J. William Funck; Corresponding Secretary, Dr. A. V. Gosweiler; Treasurer, Dr. A. T. Shertzer; Executive Committee, Drs. J. W. Chambers, D. W. Cathell and T. A. Ashby; Committee on Lectures and Discussions, Drs. Frank C. Bressler, W. T. Howard, Jr., and A. D. Mansfield; Committee of Honor, Drs. Hiram Woods, Jr., H. G. Harryman and R. G. Davis.

The newly elected president, Dr. J. F. Martenet, was then inducted into office and the Society then adjourned to the large hall to celebrate the twenty-second anniversary and banquet. Sixty-five members sat down to the banquet. Dr. John D. Blake was toastmaster, and the following toasts were drank and responded to, viz:

1st. The past history and present success of the Medical and Surgical Society of Baltimore; The outgoing president, Dr. F. C. Bressler.

2nd. Our future prosperity as a Society; The incoming president, Dr. J. F. Martenet.

3rd. What shall we do with our Medical Sisters? Dr. Thomas Opie.

4th. Progress; Dr. David Streett.

5th. What shall it profit a man if he gain great renown and have not the esteem of his medical brethren? Dr. J. E. Michael.

6th. The women of our day; Dr. William T. Cathell.

7th. Does it pay to assemble in a social way? Dr. E. M. Reid.

8th. The disadvantages of superfluous hair on the scalp; Dr. George H. Rohe.

9th. What is home without a baby? Dr. Wilmer Brinton.

10th. To what extent do the fumes of iodoform tend to increase one's reputation? Dr. J. W. Chambers.

11th. A retrospective view of things; Dr. J. W. C. Cuddy.
12th. The monthly nurse; Dr. John Morris.
13th. Advantages of being fat; Dr. J. F. McShane.
Both the menu and toasts being *very* good, were equally well discussed.
101 N. Fulton Ave. J. Wm. Funck, M. D., Secretary.

MEDICAL SOCIETY OF WASHINGTON COUNTY.*

The Society met January 11, at 11 A. M., at its hall in the Y. M. C. A. building.

The President, Dr. A. S. Mason, occupied the chair. There was a full attendance on the part of the members and the meeting was a very instructive one.

The following resolution was passed concerning the illness of Dr. N. B. Scott:

Resolved, that the Medical Society of Washington County has heard with great regret of the sudden and alarming illness of its senior member and first president, Dr. N. B. Scott, and earnestly hopes for his speedy recovery.

Resolved, that this motion be entered upon the minutes and that a copy be sent to the family. Another important resolution offered at a previous meeting, but which was amended, was unanimously agreed to and passed.

The resolution expressed the hope and desire that the physicians and residents of the county, as well as those in municipal authority here, should lend their hearty co-operation and assistance to the health officer in enabling him to take proper and due precautions to prevent the spread of, and report all contagious and infectious diseases coming to their knowledge.

It was suggested as an amendment, though not specifically embodied in the resolution, that the County Commissioners be advised or requested to give the health officer authority to take charge of and oversee all cases as above reported.

The Society recognized the fact that the statutes of Maryland give ample authority and power in the premises, but it is necessary that all co-operate with the health officer in the prosecution of his important duties.

Dr. C. L. G. Anderson read a paper having for its subject "PEACH FEVER." (See next issue of this JOURNAL.)

Dr. H. C. Foster read a paper upon A CASE OF FRACTURE OF FOREARM RESULTING IN A SUIT OF MALPRACTICE.

Dr. H. S. Herman read a REPORT OF A CASE OF PNEUMONIA. (See page 335.)

The subject for general discussion, "Abortion, its causes and management," was dropped because of insufficient time.

CHANGES IN URINE DUE TO HYPODERMIC INJECTIONS OF A NORMAL SALT SOLUTION.

(Girode, *Archiv. Gen. de Med.*) Apropos of the use of interstitial injections of saline solution in the algid stage of cholera asiatica, a word is said by Girode in regard to the consequent urinary changes. As would be expected, the diuresis is marked, during the first days especially. Urea, sulphates, phosphates are increased in the daily average, but not for the litre, while the chlorides are increased in both ways. The water of the injection is eliminated much more rapidly than the salt. About the eleventh day, following the hypodermoclysis, a certain degree of hæmoglobinuria appears, indicating a destruction of red corpuscles. The changes due to the injection cease on the sixteenth to the eighteenth day.—Johnston, *Jour. Cutan. and Gen.-Urin. Dis.*

*For the completion of these minutes we are indebted to the *Daily Herald and Torchlight.*

THE MARYLAND MEDICAL JOURNAL.

A Weekly Journal of Medicine and Surgery.

A. K. BOND, M. D., Editor.

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BALTIMORE, FEBRUARY 11, 1893.

Editorial.

MEDICAL SOCIABILITY.

There is no doubt that more good-fellowship in certain lines is very much needed in the profession of this city. The doctor in his daily rounds has but little opportunity for the cultivation of social relations to his brother practitioners. And when his day's work is done, and the business and domestic claims upon him are satisfied, he has no time nor energy left for calls upon his friends.

One might suppose that in the medical societies there would be much to stimulate friendly converse; but the tendency in our medical societies at present is to sacrifice everything to scientific interests. The programme is wholly taken up with weighty contributions, which are in many cases a most dismal bore to the physician not working in the special departments to which they relate. The consequence is that the tired doctor stays away from the modern society meeting; and, if of the older generation, longs for the good old days when the bi-weekly gathering was a time of jolly intercourse and informal exchange of medical thought and experience.

It is therefore with much pleasure we chronicle the convivial session of the Medical and Surgical Society, on the evening of January 26th, at Carroll Hall. The banquet was doubtless such as the reputation of the caterer would warrant; the toasts announced were excellent. We regret only that imperative professional calls prevented our personal enjoyment of the occasion.

Something is certainly needed to make our ordinary medical society gatherings more attractive. What this "something" is we hope to consider in a future editorial; and we would meantime be glad to publish communications from our readers upon the subject.

THE SANITARY MOVEMENT IN BALTIMORE.

For the benefit of those among our readers who have not followed closely the movement in favor of the establishment of an isolation hospital and disinfecting station in this city, we append a brief sketch of its history.

We must first credit the city Health Office with the long-continued effort which it has made to secure better sanitary equipment as far as building and apparatus is concerned; although it appears to be still blind to its urgent need for a more efficient force of inspectors in infectious disease.

The present movement seems to have owed its inception to Dr. William Welch, of the Johns Hopkins University. An impulse was given by an excellent article upon disinfection by steam, read before the State Medical Faculty last April, by Dr. E. F. Cordell, which led to the appointment by the Faculty of a special committee upon the subject. The matter was next brought to the attention of the public by Dr. Welch, who, in an address delivered this winter before the Charity Organization Society, discussed the whole subject of "infectious hospitals," and insisted upon our city's need for an institution for the reception and isolation of the common infectious diseases.

The Charity Organization Society now took the matter in hand and brought about a conference between those already interested and representatives of various mercantile bodies which were agitating the need of national and local protection against the expected invasion of cholera.

At this informal conference it was thought best that a second conference should be held, participated in by specially instructed members of the mercantile bodies. This second conference was held some two weeks later; and after hearing from a committee, of which Dr. Welch was chairman, what facilities are necessary for disinfection and isolation, it appointed certain gentlemen from each society represented to co-operate with Dr. McShane in urging upon our City Council the need for an isolation hospital, with steam-disinfecting plant attached.

Recently the committee on health, of the City Council, gave an audience to all who desired to endorse the movement, and the whole subject was pretty thoroughly discussed before them. It was agreed in this discussion that a permanent location should be at once secured near our centre of population for the erection of inexpensive permanent or temporary isolation buildings, with a disinfection station attached.

A bill embodying these propositions has been drawn up by the city law officers for presentation to the City Council, but we have not seen any allusion in the daily papers to its further progress.

The hospital will be intended for persons who cannot otherwise secure proper nursing and isolation. It is not proposed that patients already well cared for shall be removed to it.

If cholera appears it will be met by the establishment of a number of tents or wooden pavilions on lots in various parts of the city, so that those attacked may not be subjected to long and fatiguing journeys.

Medical Progress.

VIBRATIONS FOR NERVE DISEASE.

In a clinical lecture of the great Professor Charcot given in the *International Medical Magazine*, January, this subject is discussed. The lecturer says: For many years I have learned from patients who were attacked by paralysis agitans, or Parkinson's disease, that they felt much better after long trips by rail or by carriage. During these journeys they got rid of those painful sensations they had at home, and this improvement persisted for some time afterwards. Therefore I have constantly told my students that it was possible that some good could be obtained in Parkinson's disease by movements similar to those of a moving wagon or train.

Dr. Jégu then offered to construct an apparatus to carry out these ideas, and, aided by M. Solignac, an engineer, he made an arm-chair which has a special mechanism which causes it to oscillate rapidly in both its anterior and lateral axes. These combined and varied movements produce a trepidation or trembling that is similar to that felt in a running wagon. We have tried eight cases—six men and two women. An amelioration takes place after the fifth or sixth sitting. It is mostly of use for the painful sensations in paralysis agitans. As soon as the patient gets off the "trembling arm-chair" he feels lighter, and the stiffness is gone. He can walk much better, and he is able to sleep at night. This last is the most important improvement. Except in one case the trembling of the patient was not changed. This improved state is alway felt the same day of treatment, so that it should be repeated every day; but in this hospital the chair is put in motion by our electric motor, which we use three times a week for our static machines, and, indeed, even on three days a week we have not been able to give more than a quarter of an hour to each patient. This should be increased and given daily, for the results are important in this malady, where you know we have so far not been able to find anything to give relief.

My former *chef de clinique* has not contented himself with the "trembling chair" in Parkinson's disease only, but has sought to find other applications for vibration. He has had an apparatus constructed which is destined to give intense vibrations to the cranium. This apparatus is a sort of helmet with separated blades, that looks like the "conformator" used by hatters to get the shape of the head for hats. By a simple device this goes over any head. It has a plate on top on which is placed a small electric motor, moved with an ordinary battery. This gives six hundred revolutions a minute, works easily and regularly, producing a uniform vibration which is transmitted to the cranium. The whole head vibrates under it, as you can see by placing a hand on the mastoid region. When the apparatus is in motion you hear a soft humming noise, which should be taken into account in studying the results obtained by it. The number and extent of the vibrations can be regulated.

This "vibrating helmet," put on the head of a healthy subject, is well tolerated, and does not cause any annoyance. In seven or eight minutes a sensation of numbness is experienced all over the body, and the person becomes sleepy. Given for ten minutes at six P. M., a night of calm sleep will follow. Eight or ten sittings cure insomnia when it is not associated with any organic brain disease. In three cases it was found very efficacious in sick headache (migraine). Three persons having neurasthenia were treated; two were cured, while the third did not continue the treatment, although improved. This form of vibration acts in

neurasthenia by taking away, first, the cephalic symptoms, vertigo, and the painful frontal constriction which is so characteristic of this affection. What seems to show that these vibrations have a peculiar action on the brain is that in one case, where the spinal symptoms were predominant, the usual weakness of the inferior members and the sexual impotence disappeared without having to make any vibrations down the spinal column. Static electricity had failed in this patient. It cannot, therefore, be any longer doubtful to you that vibrations of this nature are a powerful sedative to the nervous system.

THE RABBITS OF AUSTRALIA.

Many of our readers have doubtless felt an interest in the outcome of the effort to rid Australia of the rabbit scourge by introducing chicken cholera among the rabbits. If the following account of a correspondent of the *Lancet* is to be believed, the utility of the method has been hindered by selfish interests:

Some years ago Madame Pommery, whose name is so familar to epicures, began to utilize some waste land over her champagne cellars for the breeding of rabbits destined to serve as food for the powder expended by her guests during the shooting season. Madame Pommery was evidently unacquainted with the rabbit scourge that has proved so detrimental to agricultural operations in Australia or she would never have made such a hazardous experiment. Finding that the rodents above ground were fast becoming more numerous than the bottles in the cellars beneath and that their burrowing threatened the stability of said cellars, she consulted M. Pasteur. That magician, by sowing chicken-cholera broadcast amongst the obnoxious animals, succeeded in killing them all in a fortnight. Fortified by this brilliant result M. Pasteur, it will be remembered, dispatched to Australia a commission headed by his relative, M. Loir, with the object of repeating the massacre on a large scale in our progressive but rabbit-ridden colony. It appears, however, that the Colonial Government had hitherto been paying so much a head for every rabbit killed and certain individuals who gained their livelihood in this way naturally objected to the putting into practice of the more expeditious Pasteurian method. The wire-netting industry was also well to the fore in the outcry raised against the Gallic Commission and the bugbear, chicken cholera, was advanced in order to frighten poultry breeders. The Government was powerless against this artfully contrived agitation and the justly offended *savants* had to content themselves with a sop—viz., the founding by the authorities of a Pasteur Institute at Sydney wherein they could, on the condition that they left the playful "bunny" strictly alone, undertake bacteriological researches that might benefit the colony in other directions.

REMOTE RESULTS OF RAILWAY ACCIDENTS.

In an interesting article read before the National Association of Railway Surgeons, 1892, on Death from Shock (*Fort Wayne Journal of the Medical Sciences*, October), Dr. Fitzgerald, of Los Angeles, Cal., gives a medico-legal view of the extent to which public carriers are liable for damages which remotely result from breach of contract or neglect of duty. He says:

As a matter of law, damages to be reasonable must be the natural and reasonable result of the defendant's act; and if of such a character as in the ordinary course of things would flow from the act, they may be recovered; otherwise they are too remote. Sackett, p. 275.

They cannot be held responsible for injurses which could not reasonably have been foreseen or expected as the result of his misconduct or of the collision. An act is the proximate cause of an event only when, in the natural course of things and under the particular circumstances surrounding it, such an act would nat-

urally produce the event, and in order to create legal liability for damages, the jury must be such as a man of ordinary experience and sagacity could foresee might probably ensue from said act. Sackett, p. 275.

The proximate cause of death from shock is one of these metaphysical questions difficult of satisfactory adjustment. It cannot be claimed that the terror or mental excitement, or even the slight bodily injury, consequent upon the collision or other accident was the proximate cause of death, and the proper conclusion to arrive at, in such cases, I have thought is this: The cars of a railroad company are not hospitals, nor are their employees nurses.

The following case is illustrative of this point: Where the plaintiff, a woman, was a passenger on a sleeping car of the defendant, which through the negligence of the defendant caught fire and the plaintiff, on account of smoke and flames, was compelled, in a half-clad condition, to leave the car and caught cold which resulted in the suppression of her menses and subsequent illness, it appearing from the evidence that such illness was of the character that results from arrested menstruation, the court held that the plaintiff being "unwell" at the time there was in her then physical condition an intermediate and independent cause of the subsequent illness which was the remote and not the proximate result of defendant's negligence. Persons who are ill have a right to enter and travel in the cars of a railroad company, and as common carriers of passengers the company has no right to prevent them, but the increased risk arising from conditions of health affecting their fitness to travel, certainly where such conditions are unknown to the carriers, must be assumed by the passenger.

THROMBOSIS OF INFERIOR VENA CAVA.

Dr. Smith (*British Medical Journal* January 7), reports a case as follows:

Having had the opportunity of watching the progress of this case from its commencement up to the present time, a period of six years and a half, I have ventured to send some notes relating thereto, together with a portrait of the abdomen of the patient.

W. S., aged 29, carpenter, family history good, personal history good, married, three children. In March, 1886, the patient was repairing stables which had not been disturbed for a century and there were no drains for carrying away the liquid manure. Whilst moving the floor, an intolerable stench was noticed and within forty-eight hours he, with two other workmen, became ill, suffering from sore throat, great prostration, and rigors. The patient's temperature ranged from 101° to 105° for four or five days. About a week after the onset of the above symptoms, the right lower extremity became swollen, the tension being such as to cause pain and sleeplessness. Six weeks later the left limb became suddenly enlarged and pale, the lower fourth of the abdominal wall and the scrotum and penis participated in the extension of the œdema.

After remaining in bed for five months, the œdema had subsided sufficiently to allow of the patient's sitting, but the skin over the anterior surface of the tibia, which for some time had shown signs of diminished vitality, sloughed, leaving a large ulcer upon each leg. At this stage of the illness, attention was directed mainly to the treatment of the ulcers, which remained open for more than two years, and were finally healed by means of skin grafting. Enlargement of the veins in the abdominal wall and femoral regions was noticed for the first time in the winter of 1888-89.

For the past two years the man has been actively engaged in his trade with the exception of six weeks last autumn when he had an attack of acute rheumatism. A mitral systolic *bruit* was audible after this illness, but previously no

evidence of any organic affection had existed. The present condition of the patient is very good and the cardiac murmur is not pronounced. All œdema has disappeared.

Remarks.—In the first instance a poison seems to have entered by the respiratory tract and septicæmia resulted. Phlebitis in the right femoral or external iliac vein, resulting in thrombosis, gradually extending up to the junction of the common iliac veins, appears to have occurred. The next stage was probably a projection upwards of the thrombus into the commencement of the vena cava and hence the sudden onset of symptoms of plugging of the main vein of the left limb and also of the veins of the scrotum, penis, and lower part of the abdominal wall. The commencing enlargement of the superficial veins probably escaped notice in consequence of the œdema of the abdominal wall. As the size of the dilated veins showing their anastomoses has now remained unaltered for two years and a half, the lumen of the commencement of the vena cava is most probably permanently obliterated. The patient's wife bore him a child in March, 1887, conception thus having taken place when symptoms of venous obstruction were most marked. The function of the testes, at that period, apparently being unimpaired, points to the fact of the entrance of the spermatic veins above the assumed site of the thrombus. The dorsal vein of the penis is somewhat enlarged' there is no varicocele upon either side, and no sign or symptom of any enlargement of the hæmorrhoidal veins has ever existed.

The accompanying photograph shows anastomoses between the superficial epigastric and long thoracic and internal mammary veins; the superficial circumflex iliac is also seen communicating with the long thoracic and lower intercostal veins.

SOME BENEFITS FROM INVESTIGATIONS IN THE PASTEUR LABORATORY.

In writing from Paris to the *British Medical Journal*, January 7th, an "old student of Pasteur's" says:

In a stable near Paris in which glanders had become endemic, and in which it was impossible to eradicate the disease, simply because no means could be found to make the diagnosis in time, the owners caused over 200 horses to be inoculated with mallein; 130 horses showed the typical symptoms produced in animals suffering from glanders when inoculated with the substance. The owners, acting on the advice of veterinary surgeons, caused these horses to be slaughtered at once; careful post-mortem examination was made on each one of them, and all without exception were proved to be suffering from glanders, although in the majority the disease was but beginning and not even suspected. Professor Nocard and M. Roux are now prosecuting these researches, and there is no doubt that by the use of this method glanders can be detected at a time when no one could suspect it, and that by early diagnosis the eradication of the disease will be rendered more easy. It is a sad fact also that the Russian observer who was one of the first, if not the first, to prepare this substance, fell a victim to scientific research, as he accidentally inoculated himself with this disease and died.

WOUNDS OF THE HEART.

Dr. George Foy, of Dublin, writes to the *Lancet:* "The annotation under the above heading which appeared in the *Lancet* of December 31st, page 1521, brings under notice one of the most important questions in medical jurisprudence and one around which centre many important historical associations. In considering the subject I think the natural division of such wounds is—(1) Wounds of the ventricles, and (2) wounds of the auricles, these being subdivided into (*a*)

penetrating and (*b*) non-penetrating. Such an arrangement seems to have been followed by the older writers, commencing with M. Morand, whose work, "Observation sur une Place du Cœur," was published in 1735. Garé noticed ("Opera Omnia," liber viii) that wounds of the ventricle cause death slowly. The great significance of this is dealt with and clearly shown by Beck in his "Jurisprudence." Baron Dupuytren gives Latour's case of "a ball extracted from the right ventricle near to the apex of the heart, and partly covered by the pericardium" six years after the injury was inflicted. William Harvey found a bullet in the heart of a stag. Even wounds that penetrate the auricle are not necessarily fatal. Dr. Grace of Fife's case lasted two days after puncture of the right auricle, and Surgeon Billy's case—wound of the right ventricle—survived five days, the longest period on record that I know of. Death may, however, very suddenly result from the wound, for, although the Duc de Berry survived his injury some hours, King Henry IV died almost immediately from the stab of the assassin Ravaillac. A very slight puncture of the auricle may quickly cause death. Two such instances are on record: (1) The Sardinian nobleman's case, in 1728, at the Court of Victor Amadeus; and (2) that of Admiral Villeneuve, who on April 22nd, 1806, killed himself by piercing the right auricle of his heart with a fine needle. But perhaps the most remarkable case on record is that reported in the *Manitoba Lancet*, vol. i, and copied by me in my article, "The Literature of Punctured and Lacerated Wounds of the Heart," in which an attempt was made to remove by operation a needle from the interior of the right ventricle of a medical student. The operation was unsuccessful, but the manipulation of the heart displaced the needle from the position in which it was causing great distress, and for years the patient suffered no inconvenience."

HYSTERICAL FEVER.

Pucci has studied this subject and concludes as follows:

1. There is an actual hysterical fever.

2. It is one of the various forms of hysteria which has been studied, especially during these latter years.

3. It is produced by a paralysis of the inhibitory cortical heat centres; it may also be caused by an excitement of the thermogenetic centres.

4. It may present itself in young, marriageable and chaste women; in adults, the married and widows. According to Salomone-Marine it is more intense and obstinate in women who lead immoral lives. It may appear during pregnancy; it does not disturb pregnancy, neither does it influence the health of the fœtus. Males are also subject to it.

5. It generally follows other hysteric symptoms of the diathesis, yet it may be an initial symptom.

6. It always accompanies the phenomena of hysteria, which may aggravate during the period of the highest temperature.

7. It may assume the quotidian or tertian intermittent type and the remittent or sub-continuous type; in the second case assuming the meningitic typhoid type.

8. It is accompanied by the ordinary symptoms of fever. It may rise to a high degree, and during the apyresia descend to 35 degrees C.

9. The same patient may present, successively, various modalities of symptoms, and, in its course, the fever may undergo notable interruptions of several days and even months.

10. No general or visceral lesion is ever to be found. Nutrition remains good; but the mental condition of the patient may be disturbed.

11. It is refractory to all the anti-thermic remedies and to the salts of quinine; but it may yield to anti-hysteric treatment.—*Lancet-Clinic.*

OVARIOTOMY IN OLD WOMEN.

At a recent session of the Southern Surgical and Gynæcological Association (*New York Journal of Gynæcology and Obstetrics*, January, 1893) Dr. Joseph Taber Johnson, of Washington, D. C., read a paper entitled "Ovariotomy in Old Women." He remarked that not many years ago a patient of sixty years of age was considered too old to undergo the operation of ovariotomy but the more rapid methods of operation and more careful attention paid to the lessening of shock have made the procedure in these cases safer and more successful. In the three cases which he had to report, he was quite sure prolonged anæsthesia and manipulation within the peritoneal cavity would have proved fatal.

He related three cases; one in a patient aged 67, one at the age of 68 and a third at the age of 67.

This last mentioned tumor had been tapped nine times in the last eighteen months, and fully four hundred pounds of fluid drawn away. Improved methods quicker operations, antiseptic technique and provisions against shock, he said, show thirty-eight recent cases between the ages of sixty-seven and eighty-two, with only two deaths against twenty-four cases, done twenty years ago, between the ages of sixty and sixty-seven, with a record of six deaths. These figures demonstrate in addition to improved technique the surprising fact that old age is no contra-indication against ovariotomy. Indeed, they seem to have endured the strain and shock equally well if not better than an equal number of younger women.

CERVICITIS AND ITS TREATMENT.

At the last meeting of the Southern Gyæcological and Obstetrical Society Dr. Bedford Brown, of Alexandria, Va., read a paper (published in the *New York Journal of Gynæcology and Obstetrics*, January, 1893) entitled "*The Simple, Septic, Traumatic and Specific Forms of Cervicitis and Their Treatment.*" Simple cervicitis arises alone from simple causes. It never originates from infection of any kind. It could exist for an indefinite time without infecting surrounding structures. For many years the author in the treatment of this affection has addressed his remedies to the interior of the cervical canal alone, whether he used nitrate of silver, sulphate of copper, carbolic acid or iodine. Septic cervicitis arises always from septic infection of the pelvic structures connected with the lymphatic communication. Contact with the os of portions of putrescent placenta, membranes, coagula or septic discharges from diseased uteri were the common causes. Antiseptic measures alone could counteract septic infection and inflammation, whether in the form of septicæmic fever or local inflammatory action.

All other agencies were simply palliative or adjuvant in character. Traumatic cervicitis was simply inflammation and congestion of the cervix from wounds inflicted on that body either during labor, abortion or from the use of dilating instruments. The author treats this form of cervicitis by means of a solution of nitrate of silver, varying in strength from a scruple to half a drachm applied in the canal and over the entire cervix. He finds most of his cases of open and all cases of concealed wounds heal by this method. Specific cervicitis may arise either from gonorrhœal or syphilitic infection. In the early stages he resorts to

douches containing peroxide of hydrogen in the proportion of one part to three-fourths of boiled water, and also permanganate of potash, one grain to the ounce of water.

DIABETES MELLITUS.

In the *British Medical Journal* of January 7, Dr. Rowland reports at length a case of pancreatic diabetes which from its somewhat erratic course presents many points of interest, among which may be noted the following:

1. Rapid improvement under treatment, upon the slightest relaxation of which sugar reappeared for two days in urine of low specific gravity, as rapidly disappearing again on the resumption of the former treatment.

2. Complete failure of the yeast test during the transitory reappearance.

3. Sudden development, two days prior to death, of a semi-comatose condition, which passed completely away after a few hours.

4. Equally sudden onset of similar semi-coma, rapidly becoming profound, and fatal in two hours, with "air hunger" breathing and acetone smell of the breath.

5. The onset of the coma occurring when urine was being passed in good quantity, and even more than on several previous occasions, being also of low specific gravity, free from sugar and not giving the ferric chloride reaction.

6. The entire absence throughout of epigastric pain and constipation, or tendency thereto.

7. The very marked fibrous and calcareous degeneration of the pancreas, together with hepatic degeneration.

LIGHT IN THE SICK-ROOM.

Dr. B. W. Richardson says that a custom still prevails, depite all our sanitary teachings, that the occupants of a sick-room in the private house should be kept at all times in a darkened room. Not one time in ten do we enter a sick-room in the day-time to find it blessed with the light of the sun. Almost invariably, before we can get a look at the face of the patient, we are obliged to request that the blinds be drawn up, in order that the rays of a much greater healer than the most able physician can ever hope to be, may be admitted. Too often the compliance with this request reveals a condition of the room which, in the state of darkness, is almost inevitably one of disorder everywhere; foods, medicine, furniture, bedding, misplaced; dust, stray leavings in all directions. In brief, there is nothing so bad as a dark sick-room. It is as if the attendants were expecting the death of the patient. And if the reason for it is asked, the answer is as inconsistent as the act. The reason usually offered is that the patient can not bear the light; as though the light could not be cut off from the patient by a curtain or screen, and as though to darken one part of the room it were necessary to darken the whole of it. The real reason is an old superstitious practice, which once prevailed so intensely that the sick, suffering from the most terrible disease —small-pox, for instance—were shut up in darkness, their beds surrounded with red curtains during the whole of their sickness. The red curtains are now pretty nearly given up, but the darkness is still credited with some mysterious curative virtue. A more injurious practice really could not be maintained than that of darkness in a sick-room. It is not only that dirt and disorder are results of darkness—a great remedy is lost. Sunlight is the remedy lost, and the loss is momentous. Sunlight diffused through a room warms and clarifies the air; it has a direct influence on the minute organic poisons—a distinctive influence which is most precious—and it has a cheerful effect on the mind. The sick should never be gloomy, and in the presence of the light the shadows of gloom fly away. Hap-

pily the hospital ward, notwithstanding its many defects—and it has many—is so far favored that it is blessed with the light of the sun whenever the sun shines. In private practice, the same remedy ought to be extended to the patients of the households, and the first words of the physician or surgeon on entering the dark sick-room should be the dying words of Goethe: "More light! more light!"—*The Druggists and Chemists' Gazette.—Medical Record.*

ECTOPIC PREGNANCY.

In an article upon this subject (*N. Y. Jour. Gynœcology and Obstetrics*, Jan., '93) Dr. Ingraham sums up the matter as follows:

When a woman, whether married or single, skips one or more menstrual periods, and is suddenly seized with sharp excruciating pain in the lower part of the abdomen, usually more marked on one side, grows faint, she may lose consciousness or not, is nauseated, possibly vomits, is unable to sit up or to walk, or walks with difficulty, has great tenderness of the abdomen, usualy more marked on one side, has a shreddy, stringy uterine discharge, and upon vaginal examination a boggy mass is felt generally at one side and posterior to the uterus, it is time for the attending physician to call on a competent consultant, unless he feels perfectly able to manage a ruptured ectopic pregnancy, as he probably has one to deal with. Even if all the above symptoms are not present, a consultation should be called. This should be done promptly, as delay has cost many lives. When rupture occurs abdominal section is the proper treatment unless the rupture be within the folds of the broad ligament when absorption generally takes place. Even then, when in doubt, operation is demanded. I believe the use of electricity in the treatment of this condition is worse than useless—it is trifling with human life.

MICRO-ORGANISMS OF ULCERATIVE ENDOCARDITIS.

A paper on the above subject appears in the *Lyon Médicale* of Dec. 18th, 1892.

The case upon which the observations were made was that of a girl aged nineteen. The diagnosis was confirmed on post-mortem examination. In order to procure the organisms one of her fingers was carefully cleansed, first with soap-and-water, then with ether and finally with corrosive sublimate solution; a drop of blood was obtained by pricking the finger with a sterilized needle and placed in bouillon. The culture medium was kept at a temperature of 35°C., and rapidly became cloudy. On microscopic examination a diplococcus was found rather larger than the staphylococcus pyogenes. The elements of the diplococcus appeared occasionally to be single, but they never formed in chains or in groups. They did not possess a capsule. The organism stained well with all the aniline dyes and also by the Gram method. It could be cultivated at any temperature between 13° and 14° C. The cultures in bouillon very quickly caused a turbidity in, and gave a well marked yellow tinge to, the liquid. The culture obtained its maximum of growth in about forty-eight hours, but ceased to increase in about seven or eight hours after that time. A copious yellow deposit formed on standing, but the supernatant liquid remained cloudy. Cultures on agar-agar glycerine grew rapidly, and well marked colonies were observed at the end of twenty-four hours at a temperature of 37°C. On the surface of the cultivating medium a very slight white pellicle was noticed with somewhat festooned borders; this appearance extended into the agar-agar. If a culture was made by running the needle deep into the agar-agar, a white streak was produced in the course of the needle, but it presented nothing which could be called characteristic. On gelatine the diplococcus did not grow so well—the gelatine was not liquefied. Occasionally on the surface a pellicle similar to that produced on agar-agar was noticed. In plate cultivations this was shown to consist of minute, opaque, yel-

lowish-white colonies. A rabbit was inoculated with a broth-culture, but no effect was produced. The animal was killed on the tenth day, but no lesions could be detected.—*Lancet.*

CHRONIC CONSTIPATION.

Dr. Kussmaul, formerly Professor of Clinical Medicine at Strasburg, was the first to make use of oil enemata in the treatment of chronic constipation. This method is little known out of Germany where it is somewhat extensively used, and an account of it may prove useful and interesting to our readers. The following is the procedure adopted by Dr. Fleiner, Professor Extraordinary of Dermatology and Syphilography at the Medical Faculty of Heidelberg, who is a zealous supporter of Prof. Kussmaul's method.

Professor Fleiner distinguishes two varieties of chronic constipation, viz., the atonic and the spasmodic.

These two forms of chronic constipation are sometimes found combined. The lower half of the large intestine is then in a state of spasmodic contraction whilst the upper half is atonic and distended with gases and fæces.

The distinction between atonic and spasmodic constipation is of the highest importance as regards treatment. Electricity, massage and laxatives which are so efficacious against the former, not only fail in the latter but are actually harmful, for the spasm of the intestinal wall is increased by the irritation produced.

Better results are obtained in some cases from the administration of narcotics, particularly belladonna and hyoscyamus, and of warm injections of infusion of chamomile, peppermint, anise, etc., but these means also very often prove inefficient.

Olive oil injections, however, constitute a ready and safe way of relieving even the most obstinate cases of spasmodic constipation. The oil exerts a stimulating and soothing action on the intestine. It can also be used in cases of atonic constipation but as this is relieved by other means of a still simpler kind, the injections are especially indicated in cases of mixed and spasmodic constipation.

For purposes of administration, Professor Fleiner employs a canula with a bulbous end, similar in appearance to an ordinary vaginal tube and large enough to allow of the easy discharge of the oil. The canula is connected by means of a flexible tube with a syringe containing from four to five hundred grammes (about fifteen ounces) of pure oil. The patient is made to lie on his back with the pelvis elevated, the canula is introduced and the oil injected slowly. The operation usually takes from fifteen to twenty minutes. The canula need not be passed very high up the rectum, for, by placing the patient in the position above described, intestinal pressure is lowered and the oil is, as it were, aspirated by the intestine.

For some time after the injection, the oil gives rise to no sensation whatever, but after a while the patient feels a desire to pass wind. There is no pain if pure oil is used. At the end of a few hours, in the morning if the enema was administered at night, a more or less abundant evacuation is produced which contains only half the quantity of oil injected. The remainder is retained and gradually passed in the course of ten days or a fortnight.

The injection is repeated daily until the intestine is cleared of its contents. Two or three enemas are usually sufficient for that purpose. When this has been done, the effect is kept up by means of an injection of two hundred and fifty to three hundred grammes (about ten ounces) of oil at intervals of a few days.

When the intestine is very much distended with fæces, the first injection may not succeed in moving the bowel. In such cases an enema of water is given a few hours after the oil injection.

Nothing but pure oil of good quality should be used, that is to say, oil free from all rancid and acid principles which are apt to give rise to colic. Needless to say that the apparatus should be kept scrupulously clean. After each operation the tube and canula are cleaned by washing first with alcohol and then in water.

Apart from chronic constipation which is so frequently met with in neurotic subjects, in anæmia and various gynæcological affections, oil enemeta are also very useful according to Professor Fleiner in the treatment of membranous colitis, in typhlitis, rectal inflammation and intestinal disturbances connected with disease of the stomach.—*Medical Week.*

Recommendations of Therapeutic Agents.

John V. Shoemaker, A. M. M. D., Philadelphia, writes as follows: Phenacetine was originally introduced into medical practice as an antipyretic, and subsequently was found to possess analgesic powers. In diseases attended by hyperpyrexia, such as rheumatism, pneumonia, typhoid fever and phthisis pulmonalis, phenacetine exerts a very happy effect in about half the dose of antipyrine, the ordinary dose being from 3 to 8 grains. The mortality of the typhoid fever of children has been very materially reduced by the employment of phenacetine. The fall of temperature does not occur until half an hour after the drug has been taken and the effect continues from four to eight hours. As as antipyretic, phenacetine is considered by many good authorities as the safest and most efficient member of the aniline group. In epidemic influenza, phenacetine rapidly relieves the muscular pains and favors diaphoresis; the catarrhal symptoms subsequently require other remedies. In ordinary colds, one or two 5 grain pills of phenacetine remove all symptoms. The combination of salol (or salophen) with phenacetine is especially useful in influenza and rheumatism. The analgesic effects of phenacetine are very marked in various forms of headache, including migraine and the headaches from eye-strain, having the advantage over antipyrine in not so frequently causing a rash. In the neuralgic pains of tabes dorsalis, in herpes zoster, and intercostal neuralgia, 5 grain doses given every hour, for three or four hours, usually afford complete relief and cause sleep. Phenacetine is extremely useful in chronic neuritis, and according to Kater is unsurpassed in the treatment of cerebral disorder due to excessive indulgence in alcohol drinks. In whooping-cough, $\frac{1}{2}$ grain doses dissolved in 10 drops of glycerine are readily taken by children, and afford prompt relief, permitting sleep and ameliorating the attacks. In delirium, a dose of 10 grains of phenacetine will usually afford a quiet night. Mahnert considers phenacetine a specific in acute articular rheumatism, as it reduces fever, relieves pain, and lessens the duration of the attacks. It has been found useful in some cases of gonorrhœal rheumatism, and is worthy of more extended trial in this rebellious affection. Given several hours before the time of the paroxysm of intermittent fever, it prevents the chill. In insomnia from simple exhaustion, phenacetine acts admirably.—Shoemaker, Materia Medica, Pharmacology and Therapeutics, Vol. II.

Medical Items.

Dr. Robert Ward, State Veterinarian, will deliver a course of lectures at the Maryland Agricultural College. It is proposed to establish a chair of veterinary surgery at the college. Dr. Ward has prepared colored maps and drawings for use in illustrating his lectures. The object of establishing the chair is to aid in stamping out diseases of animals in Maryland and to decrease improper medical treatment of animals.—*Ex.*

It is reported in the daily press that the epidemic of cerebro-spinal meningitis has assumed alarming proportions in the neighborhood of Lonaconing, Md. It first attacked only children, now grown persons are succumbing, and great fear of it is felt among the people. On February 6, three funerals took place, and next day four corpses lay awaiting burial. An undertaker, while trimming a casket Saturday, became suddenly ill and is in a precarious condition. Several families will remove until the epidemic declines.

A dispatch to the *Sun* dated Feb. 7th, from St. Louis, says: A sensation was created to-day by the announcement that eighty students attending the College of Physicians and Surgeons, at the corner of Jefferson and Gamble Streets, had left for home this morning on account of the sudden death of three students. The excitement was intensified by the report that the deaths were caused by what is feared to be typhus fever. The dead are George Herndon, of Western Kentucky, who died Friday; Fred. H. White, of San Antonio, Texas, died this morning, and David H. Brown, of this city, died this afternoon. The students were attacked by symptoms which the physicians were unable to ascribe to virulent scarlet fever, cerebro-spinal meningitis or cerebral typhus, and in issuing the death certificates the facts were submitted to the health department. In the case of student White, the health commissioner issued a certificate of scarlet fever. It is believed the disease was contracted in the dissecting-room.

The trustees of the Johns Hopkins University held their monthly meeting Feb. 6. The board was in session for an unusually long time, and had an animated discussion over a letter from Miss Mary E. Garrett, which referred to the examinations for matriculation in the proposed medical school to which women are to be admitted on equal terms with men. The school, by a vote of the trustees, is to open in October next. Last December Miss Garrett placed at the disposal of the trustees $306,977 to make up the sum of $500,000 which was required by the trustees to be made available for the medical school before its establishment was to become a fact. She also gave $47,787.50 to the sum raised by the committee of Baltimore women toward the fund of $100,000 which was required by the trustees before women could be admitted to the medical school of the university. This sum is part of the $500,000 endowment, and Miss Garrett's total contribution was $354,764 50. The conditions under which the $306,977 were given were set forth in a communication to the trustees, and the board agreed to accept them. The curriculum of the new school, together with the studies required in the examination for entrance and enrollment of students, which had been prepared by a committee of the hospital physicians, did not, it is said, meet with Miss Garrett's approval, and in her letter, which was before the board for action yesterday, she made, it is stated, a vigorous objection to their adoption. A committee of the board was appointed to confer with Miss Garrett to endeavor to adjust matters so that they will be satisfactory to all concerned. The committee will report at a future board meeting.—*Sun.*

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Original Articles.

NOTE ON THE USE OF CAMPHORIC ACID IN THE NIGHT SWEATS OF PHTHISIS.

BY WILLIAM T. HOWARD, JR., M. D.,

Lecturer on Pathology and Instructor in Clinical Medicine in the Baltimore Medical College; Visiting Physician to St. Joseph's Hospital and to the Maryland General Hospital.

According to Combemale,* camphoric acid, made by heating camphor with ten times its weight of nitric acid, occurs as thin flakes or colorless needles, is transparent, bitter to the taste, and melts at 70 degrees Centigrade. It is slightly soluble in cold water, freely soluble in alcohol, ether, the fatty acids, and in essences.

Leu† gave camphoric acid in doses of 30 grains to phthisical patients for nights sweats with good results. In some cases he found it necessary to give as much as from 45 to 75 grains before sweating was fully controlled. In his experience this drug was decidedly more efficacious than atropia and he noted no disagreeable symptoms after its use. He also found alcoholic solutions of the drug useful in local sweating.

Hartlieb's‡ experience with camphoric acid was even more satisfactory. In

*Combemale, Abstract in the Medical News, February 28, 1892.
†Leu, Abstract in the Year-Book of Treatment, 1891.
‡Hartlieb, Abstract in the Year-Book of Treatment, p. 61, 1891.

12 out of the 13 cases of phthisis with night sweats in which it was used by him sweating was entirely controlled. Doses of 15 grains were usually sufficient, though in some cases 30 grains were required.

Hare§ tried the drug in about ten cases with good effect. This observer praises it highly, not having met with a single case in which it failed. He gave it usually in 20 grain doses. In one case of advanced phthisis with profuse and wasting sweating, after other anti-sudorific remedies had failed, a dose of 20 grains of camphoric acid given one hour before the usual time of sweating entirely controlled this disagreeable symptom. After this a single dose every 24 or 48 hours was all that was necessary to check the sweating. He also claims that good results follow its use in the sweating of nervous exhaustion and general debility. In his experience no gastric irritation or other untoward syptom followed its administration. He further calls attention to the fact that camphoric acid does not cause the unpleasant symptoms, such as dryness of the throat and feverishness of the skin, so common after belladonna.

James Wood‖ obtained gratifying results with camphoric acid in a large number of cases of phthisis in various stages. He thinks that the best effects are gained by the exhibition of 20 grains from four to six hours before the time of the expected sweating. In the ten cases reported by Wood, a few such doses were followed by prompt and often lasting relief. In one of his cases, that of a young man with great weakness and profuse sweating, two such doses were followed by complete control of the sweats, which did not return for four months. In his cases cessation of the sweats occurred whether or not the physical condition of the patients improved while under treatment.

The following cases upon which my experience with the use of the drug rests occurred during my service at St. Joseph's Hospital in April, May and June, 1892. The results obtained were so satisfactory that I have thought them worth reporting in some detail.

Case I.—Tuberculosis in the apex of both lungs, with cavity formation at the left apex. Profuse night sweats completely controlled by camphoric acid.

A. C., female, German, single, æt. 19 years. Entered St. Joseph's Hospital in March, 1892, complaining of cough, dyspnœa, weakness and night sweats. Family history good, patient has had no other illness except scarlet fever in childhood. Present illness began six months since with evening fever, cough, dyspnœa, pain at both apices, and profuse night sweats; she has not menstruated for six months. When examined by me April 1st, she was fairly well nourished and had rosy cheeks; her chest was well-shaped. There were physical signs of consolidation at both apices, and at the extreme left apex the signs of a small cavity. The heart sounds were normal, the liver, spleen and abdomen negative. The urine was normal. Tubercle bacilli in the sputum. April 4th: Patient has had profuse night sweats since admission; these are not controlled by

§Hare, Medical News, April 4, 1891.
‖Wood, Medical News, March 12, 1892.

atropia or sulphuric acid. At 2.30 P. M., given 10 grains of camphoric acid. April 5th: Profuse sweats last night. At 2 P. M., given 20 grains of camphoric acid. April 6th: Very little sweating last night; drug omitted. April 7th: Very slight sweat last night; at 2 P. M., given 20 grains of camphoric acid. April 9th: There has been no sweating since last note; the drug has been omitted. To-day at 2 P.M., given 20 grains of camphoric acid, making 70 grains up to date. April 15th: The drug has been omitted since last note; there was slight sweating the last two nights. To-day at 2 P. M., given 15 grains of camphoric acid. April 21st: Has had no sweats since the last note; has had to date 85 grains of the acid. After this it was found that a dose of 10 grains of the acid given every third or fourth day completely controlled sweating, but that if the drug were left off for a week at a time the sweating returned, very slight at first, but gradually increasing in severity. During this trial all other drugs were avoided as much as possible. She was on the house tonic of iron, quinine and strychnine. She left the hospital in June much improved and free from sweats.

Case II.—Acute tuberculosis of both lungs, with extensive cavity formation. Profuse night sweats, completely controlled by camphoric acid.

E. White, U. S., single, æt. 26 years, a teacher. Complained of cough, dyspnœa, loss of flesh, and night sweats. Father and mother both dead of phthisis. The patient has had measles and typhoid fever. He dates his present illness from an attack of influenza in December last. Has had night sweats since February. When examined by me on April 1st he was very much emaciated. There were well-marked and extensive signs of consolidation and cavity formation in both lungs. Heart, liver and other organs negative. There were numerous tubercle bacilli in the sputum. The urine was negative.

April 4th: The patient has had profuse night sweats for the last week, during which time nothing has been taken to control them. Previous to this they were only feebly affected by atropia and sulphuric acid. To-day at 2.30 P. M., given 10 grains of camphoric acid. April 5th: No sweating last night. Drug omitted. April 6th: Slight sweating last night. Drug again omitted. April 7th: Moderate sweating last night. To-day at 2.30 P. M., given 20 grains of camphoric acid. April 8th: No sweating. At 2 P. M., given 20 grains camphoric acid, making 50 grains to date. April 21st: Has had no drug and no return of the sweats since last note. April 28th: Slight sweating last night. At 2 P. M., given 10 grains of camphoric acid. April 29th: No sweating last night. At 2. P. M., given 20 grains of the acid. June 1st: Has had no return of the sweats since last note; is very much improved. No drug except camphoric acid has been given for the sweating, and the only other drugs exhibited during this time have been creosote and oleum morrhuæ, which he had taken since admission to the hospital. This patient was sent to the country, where he died in July.

Case III.—Chronic fibrous tuberculosis of both lungs. Troublesome night sweats completely controlled by camphoric acid.

A. A., German, single, laborer, æt. 34 years. Entered St. Joseph's Hospital March 13th, complaining of cough, dyspnœa, hoarseness, fever and profuse night sweats. Family and personal history negative.

Examination:—A thin, emaciated, sparely built man. On admission temperature was 102, pulse 70, and respirations 30. Chest narrow, thin, costal angle narrow. The supra- and infra-spinous fossæ are deep. Expansion deficient at both apices; the tactile fremitus is also increased here. Percussion, dulness in front at both apices as low as the second rib, behind as low as the spine of the scapula; clear elsewhere. Auscultation, at both apices, anteriorly and posteriorly, the respiratory murmur is harsh, accompanied with fine and large moist and crackling rales. At the left apex there is marked tubular breathing, but no distinct cavity formation. Moister rales are heard as low as the angle of the scapula and well into the axilla. The heart is negative, except that the pulmonary second sound is accentuated. The liver, spleen and abdomen are negative. The sputum contains tubercle bacilli in large numbers. The urine is negative. The patient was put to bed for observation, and all drugs withheld except half ounce doses of the compound tincture of cinchona three times a day. For the three succeeding nights there were profuse sweats. April 3rd, at 4 P. M., was given 10 grains of camphoric acid. April 4th: Sweats lessened in amount; at 2 P. M., 20 grains of camphoric acid. April 5th: Sweats diminished; at 2 P. M., 20 grains of camphoric acid. April 6th: Sweats notably diminished. At 2 P. M., 20 grains. April 7th: No sweats last night; drug omitted to-day. On April 8th, 9th and 10th, 20 grains of camphoric acid were given each day; the drug was then left off entirely. In all, 130 grains were given him. April 21st: Patient has not sweated since the night of the 6th. He has had for two days a copious diarrhœa, for which morphia and a bismuth mixture have been given. Death took place on the 22nd.

Case IV.—Chronic fibrous tuberculosis of both lungs. Troublesome night sweats controlled by camphoric acid.

Lewis Flynn, æt. 20, single, U. S. Entered St. Joseph's Hospital in February, 1892, complaining of cough and dyspnœa. Family history negative. Patient had scarlet fever as a child. Has also had rheumatism. Has had night sweats for some time. At times has pains in his ankles and knees, and walks with difficulty. Examined by me April 1st, when the following note was made:—Patient is very thin and emaciated, skin and mucous membranes pale; ribs are prominent, especially on the left side. Here the intercostal spaces are broad and sunken. The clavicular notches are deep. There is visible pulsation on the left side in the 2nd, 3rd and 4th interspaces. In the 2nd and 3rd interspaces the pulse is presystolic, in the 4th interspace systolic. In the 4th, just to the right of the apex beat, there is a slight systolic retraction; this is preceded by a slight presystolic bulging in the apex. The apex beat is in the 4th interspace inside the nipple line. There is a slight bulging in the precordial region, and an apparent bulging in the 4th and 5th interspaces on the right

side just to the right of the sternum. The cardiac dulness extends from the upper border of the 3rd rib and mid-sternum to the apex beat. There is no thrill. At the apex the first sound is loud and muscular, and has a metallic valvular quality; the second sound is clear. Both sounds clear at the base. At the pulmonary cartilage the second sound is accentuated and reduplicated. There are no murmurs.

Lungs.—Expansion is deficient everywhere, but especially on the left side in front. On the right side at the apex the percussion note is high pitched as low as the third rib in front and the spine of the scapula behind. At the left apex there is dulness over a considerable area in front; behind there is dulness as low as the mid-scapula region. The tactile fremitus is markedly increased on this side. Auscultation, coarse, dry and moist rales and bronchial breathing at both apices; vocal fremitus increased. At the left apex there are the signs of a small cavity.

The liver dulness begins at the sixth rib and extends to the costal margin. The spleen and abdomen are negative. The right knee-joint is somewhat swollen, but it is not tender. The urine is negative. The sputa contain a few tubercle bacilli. This interesting case was looked upon as one of chronic fibrous tuberculosis of the lungs with secondary hypertrophy and dilatation of the right heart.

April 3rd, for some nights has had sweats. Last night sweat profusely. To-day at 4 P. M., given 10 grains of camphoric acid. April 4th: No effect. At 2 P. M., 20 grains of camphoric acid. April 5th: Sweating diminished last night. At 2 P. M., 20 grains of camphoric acid. April 6th, 7th, 8th, 2 P.M., 20 grains of camphoric acid. The sweats notably decreased and on the night of the 7th there was no sweating, 90 grains having been taken in all up to date. April 17th: There was slight sweating last night, the tenth day since any of the drug had been given. To-day at 5.30 P. M., 20 grains of camphoric acid were given. April 18th: Some sweating last night till 1 A. M.; after that, none. On April 20th he got 10 grains, on the 21st, on the 22nd and on the 24th, he got 15 grains. On the night of the 26th, there were slight sweats, and 20 grains were given on the 27th. There were no more sweats for three nights. Afterwards it was found that if the drug were given in 20 grain doses every third or fourth day the sweats were effectually controlled. It is interesting to note that in this case the resistance to the drug was stubborn and that sweating recurred if the drug were omitted for more than three or four days. During the trial of the drug on this patient, oleum morrhuæ, and iron, quinine and strychnine were given, as the condition of the patient did not justify us in withholding them. At the same time that the camphoric acid was being given it was thought necessary to give the salicylate of soda, to relieve the great pain associated with the chronic rheumatism with which the patient had suffered for some time.

Case V.—Chronic tuberculosis of both lungs with consolidation and cavity formation; acute alcoholism; profuse night sweats incompletely controlled by camphoric acid.

W. K., æt. 32, married, U. S., laborer. Entered St. Joseph's Hospital April 16th, 1892, with acute alcoholism.

Family history: Mother died with phthisis; the rest negative. Personal history: Patient denies syphilis; is strongly alcoholic. For about one year has had a cough and dyspnœa on exertion. Says he has not had night sweats. He had been on a week's spree before his admission to the hospital.

Examination.—April 17th: Temperature, 101; pulse, 90, weak, of poor volume; respirations, 28. Is thin and emaciated and weak. The conjunctivæ are injected. Chest is fairly well formed; the right supra-clavicular notch is deep. Expansion is deficient at both apices. There is dulness to the second rib on the right side anteriorly and to the mid-scapula region posteriorly. On the left side there is diminished resonance at the apex anteriorly and as low as spine of the scapula posteriorly. Tactile fremitus is increased at both apices anteriorly and posteriorly. At the right apex anteriorly and posteriorly there are loud dry and moist rales, with bronchial and cavernous breathing, bronchophony and pectoriloquy. Below the second rib moist sounds are heard everywhere. On the left side, at the apex anteriorly and posteriorly, coarse and fine moist sounds are heard with puerile respiration. These are best heard in the interscapula space. The heart is negative except accentuation of the pulmonary second sound. The liver dulness begins at the 6th rib in the mammary line. Abdomen and spleen are negative. Urine negative. The sputum contains tubercle bacilli in large numbers. April 21st: Since admission has had profuse sweats each night. Complains very much of weakness, and begs hard for whiskey, which is withheld except three doses of a tablespoonful each day. At 2 P. M., to-day, given 20 grains of camphoric acid. April 22nd: Sweated less last night. At 2 P. M., 10 grains. April 24th: Sweats, though less persistent. On this and the six succeeding days at 2 P. M., he got 20 grains of the acid, making 170 grains in the nine days. The sweats were notably diminished, but were not completely arrested on any single night. He was discharged improved May 1st.

Case VI.—Chronic fibrous tuberculosis of both lungs; tubercular laryngitis. Profuse night sweats completely controlled by camphoric acid.

J. S., æt. 60, laborer, U. S., admitted to St. Joseph's Hospital April 7th, 1892, complaining of weakness, hoarseness, cough and dyspnœa. Family history strongly phthisical. Personal history: never sick till last winter a year, when he had the influenza. Since then he has had a cough; later he had two profuse hæmorrhages. He has lost 25 pounds in weight. Appetite is poor, bowels constipated. The supra-clavicular notches are deep. There is at each apex dulness and increased fremitus as low as the second rib in front and the spine of the scapula behind. Over these regions are heard loud blowing breathing, coarse and fine moist and dry rales. Over the posterior portions of each lung there are numerous fine moist rales. The heart, liver, spleen and abdomen are negative. Examination of the urine negative. He says he has had profuse night sweats since December, 1891. April 8th: Had profuse sweats last night.

Given 20 grains of camphoric acid, to-day. April 9th: No sweat last night. Camphoric acid 20 grains to-day. April 14th: No sweat since last dose, with the exception of last night. To-day given 20 grains at the usual time. Examination shows both vocal cords ulcerated. April 24th: Slight sweat last night, the first since the last dose, 10 grains of camphoric acid, making 70 grains to date. June 15th: No sweating since last note. Up to the first of June the patient improved, since then he has steadily lost ground and becomes weaker. Other drugs taken have been ½ oz. each of whiskey and ol. morrhuæ and 1-30 grain of strychnine threee times a day. For the distressing cough inhalations of tr. benzoin comp. were used in the day and hyperdermics of morphia at night. This patient died the last of August. At the autopsy extensive tuberculosis with cavity formation was found in both lungs.

Case VII.—Chronic diffuse tuberculosis of both lungs with cavity formation. Profuse night sweats controlled by camphoric acid.

C. B., white, æt. 32 years, widow, U. S. Entered St. Joseph's Hospital April 21st, 1892, complaining of cough, pains in chest, and night sweats. Family history negative. Personal history: Has had no children, but one miscarriage. Had measles, varioloid and pneumonia when young. In December, 1892, she was taken sick with a severe cold, accompanied with a cough and profuse perspirations. Since then she has had several hæmorrhages and has lost much flesh. Appetite is fair, and her bowels are regular. Lately has had profuse night sweats. On admission, her temperature is normal, pulse 90, regular; respirations, 24. Her skin and mucous membranes are pale. The chest is narrow and shallow, the costal angle acute. There is bulging of the second rib on each side, and a deep depression above and below the left clavicle. Expansion is deficient everywhere, but most so at the left apex. There is slight loss of resonance at the right apex. At the left apex there is dulness as low as the second rib in front and the mid-scapula region behind. At the right apex on deep inspiration there are fine moist rales, and broncho-vesicular respiration. Expiration is prolonged. In the right inter-scapular region there is in addition intense bronchial breathing. Left lung: At the apex in front and extending to the second rib there is intense cavernous respiration, with bronchophony and pectoriloquy. Over the entire anterior surface of the lung there are moist rales. Posteriorly at the apex the signs of a cavity are marked. Coarse and fine moist and dry rales are heard everywhere. Heart negative, except accentuation and reduplication of the pulmonary second sound. Liver, spleen and abdomen negative. Examination of the urine negative. April 22nd: Profuse sweating last night. At 2 P. M. to-day, given 20 grains of camphoric acid. April 23rd: Sweat last night, though less than the preceding night. Dose repeated to-day at 2 P.M. April 24th: No sweat last night. At 2 P. M., 20 grains of camphoric acid, making 50 grains to date. April 29th: Slight sweat last night, the first since the last note. To-day given 20 grains of camphoric acid. There was no sweating till the night of May 4th, when there was a heavy sweat. On May 5th,

given 10 grains of camphoric acid. On three days next succeeding 20 grains were given each day, making 140 grains to date. There was no sweating till the night of the 10th, lasting about one hour. Given 20 grains of camphoric acid to-day, making 150 grains in all. July 15th: There have been no sweats since the last note. The patient has steadily improved. During this time she has taken ol. morrhuæ, and strychnine. For a time she also received creosote. This patient died September last of peritoneal tuberculosis in addition to the lung affection, in another hospital.

Case VIII.—Acute rheumatism. Profuse sweating completely controlled by camphoric acid.

M. Z., æt. 23 years, single, laborer, a Russian Pole. Entered St. Joseph's Hospital May 30, 1892, complaining of swelling of the right shoulder and of the left wrist, fever and sweating. Family history negative. Personal history: Has had measles, rheumatism and bronchitis, and the past January, influenza. Four weeks ago the patient had a chill followed by fever. He dates his present illness from this. Since then he has had pain in and swelling of the right shoulder. Three days ago the left wrist became similarly affected. At this time he had another chill followed by fever and profuse sweating.

On admission, temperature is 102.5, pulse 94, respirations 20. The following note was made. A strong, well-built man, skin warm and bathed in a profuse sweat. Eyes normal. Chest well-shaped; lungs negative. Heart sounds clear, except for a soft systolic murmur at the aortic cartilage. Liver, spleen and abdomen negative. There is no discharge from the penis; no sore or scar to be found. The inguinal glands are slightly enlarged. There is no swelling of the shoulder joints or of the wrists, but there is some pain on motion of the right shoulder and the left wrist. The left knee is swollen and tender and measures 2 c.m. more in circumference than the right. There is some fluctuation. Both ankles are slightly enlarged and tender; as are the metacarpo-phalangeal joints of each great toe. He was given a calomel purge and at 4 P. M., 20 grains of camphoric acid. May 31st, 10 A. M., temperature 98.5, pulse 80. The skin over the face and body is dry; has had no sweating since the dose of camphoric acid. 4 P. M., 20 grains of camphoric acid; no other drug is being taken. Temperature is 102.5, pulse 90. June 1st: Temperature to-day runs the same as yesterday. The skin is hot and dry. The joints are more swollen and painful; the right shoulder is now swollen and very painful. No drug of any kind given to-day. June 2nd: Patient is much the same; the temperature still rises to 102.5 in the evening. The joints are more painful than ever. Morphia 1-6th grain given hypodermically for the pain. There has been no sweating since the administration of the camphoric acid, of which 40 grains have been taken. June 3rd: Ordered salicylate of soda, 15 grains every three hours. On June 5th, the sweating returned and kept up for several days. After the administration of the salicylate of soda the temperature gradually fell to normal, the swelling and pains in the joints diminished. This patient finally made a good recovery without any cardiac complication.

The camphoric acid was usually given as a powder on the tongue, followed by a little water. The taste is not objectionable and patients do not mind it. A very good way is to give it in capsules of 10 grains each. In order to avoid as much as possible any mental influence, the purpose for which the drug was administered was withheld from the patients. As a rule, however, they connected the administration of the drug with the cessation of the sweats, and would ask on the recurrence of the sweating for another dose of the white powder to-day.

A study of the charts of these cases of phthisis does not show any appreciable change in the temperature, pulse, or respiration that can be attributed to the influence of the drug. Beyond the relief of a very disagreeable and distressing symptom, the drug seems to be entirely without influence over the course of the disease.

Reference to the cases will show that in nearly every case a small dose (10 grains) was given at first. This dose, though it usually diminished the sweating, was not found sufficient to entirely control it. Larger doses (20 grains) were followed by very satisfactory results. It is striking that when once the system was under the influence of the drug, sweating did not recur for some time, and that then smaller doses, given at irregular intervals, were sufficient to hold the sweats in check. In some cases after several doses there was a complete absence of sweating for some time. In no case was there any gastric disturbance or any other disagreeable symptom. The only secretory glands that seemed to be affected were the sweat glands. As far as could be determined the drug is perfectly harmless and its administration is not followed by any deleterious action upon the system.

The exhibition of camphoric acid in the case of rheumatism was rather as an experiment than as a therapeutic measure. The idea was to see if the drug had the power of checking sweating in the acute infectious diseases, and it is regretted that other and a varied set of such cases did not present themselves at that time. In this case the sweating was completely checked, but as far as could be seen the drug exerted no influence over the course of the disease and had no antipyretic action. It will be interesting in a further study of camphoric acid to note its effect upon the sweating stage of the continued fevers. In suggesting this I do not wish to be understood as taking the ground that the arrest of sweating is a thing to be desired in all cases of this class. However, there is a certain class of such cases, as the cold clammy sweating of typhoid fever and the septicæmias, where this symptom appears to be due more to a general nervous debility than to a means of nature to eliminate the poison.

In such cases, it is suggested that camphoric acid promises to prove a valuable remedy against a very distressing symptom.

In conclusion, I wish to express my indebtedness to Dr. Frank J. Kirby, Resident Physician at St. Joseph's Hospital, for his careful attention in keeping accurate records of the cases reported.

804 Madison Ave.

PEACH FEVER.*

BY C. L. G. ANDERSON, M. D., HAGERSTOWN, MD.

"Environment makes the man." "Der Mensch ist was er isst." I will go further, and say that a man thinks what he eats. Having worked among and eaten of peaches the past season, it was but natural that, when called upon to present a paper before the Society, I should select the subject I have.

Considerable attention has been paid during the last few years to diseases incident to occupation. Being practically engaged for several seasons in peach culture, I could not fail to observe the effects of the business upon those taking part therein.

There are two varieties of peach fever:

1st. Psychotic variety, expressed by mental exaltation, and ideas of grandeur, and which is the product of a lively imagination.

2nd. Peach fever proper, which it is the province of this paper to introduce to the profession.

It is well known that the yearly revival of vegetable life sets free in the atmosphere small particles of organic matter which irritates the respiratory passages. Peach fever is a morbid condition of the respiratory tract and cutaneous surface, together with subsequent systemic disturbance, due to irritation from the pubescence of the skin of the common peach—amygdalus persica.

From the hairy premature in June to the woolly Smock in September, there is given off from the various varieties of the peach a vegetable irritant which commonly passes under the name of fuzz. I have not observed that the pollen causes any deleterious effects. The fuzz, however, irritates the air-passages, the conjunctivæ, and its skin; the latter, especially when perspiring and chafed.

In this climate the Schneiderian membrane is always in a resentful state. It soon becomes inflamed, and exudes a large amount of serum. This is accompanied with swelling, snuffling, fulness, and frontal headache. The conjunctivæ weep from the same cause, and the eyes become reddened and suffused.

On account of the more or less occluded nasal passages, mouth-breathing is necessary and the fuzz is carried further down the respiratory tract. As a result of the irritation, the mucous membrane becomes tumefied and secretes a serous exudate, which, sooner or later, turns into a viscid tenacious mucus, which is hard to dislodge. The larger bronchi, even, are invaded, and an asthmatic, wheezy cough is developed. The asthma may also be reflexive.

On the skin the effects are exhibited mainly upon the wrists and forearms, the neck and upper part of the trunk, and the forehead under the hatband. It will be seen that these exposed parts are likewise subject to chafing from the clothing. From the combined effects of the peach-down, sweat and friction, the skin becomes inflamed, and a macular eruption, similar to what is commonly called "heat," is developed. If, on account of the accompanying pruritus, the sufferer

*Read before the Washington County Medical Society, January 11, 1893.

further irritates the parts by rubbing and scratching, a moist eczematous condition is induced in which there is a true dermatitis.

I noticed one case in which there was a scattered pustular eruption on the neck and shoulder.

It will readily be seen that a case in which there is both respiratory and cutaneous inflammation will exhibit a systemic discomfort measured by a rise of one or two degrees in temperature. I know of one case, a young woman, compelled to quit work for this reason.

Men, women and children are engaged in the work. The men usually do the picking, while the women stay under the shelter and pack the fruit for market. Both pickers and packers are subject to these unpleasant symptoms, but the pickers are more liable, as they work in the hot sunlight and perspire more. The women protect their necks with closely drawn sunbonnets and their wrists with long gloves, while the men soon learn that it is best not to scratch the itching parts. I have seen a few women wear veils, and several men use moistened sponges as respirators. Of course, there are pachyderms whom all this does not affect; but neurotic and tender-skinned young girls suffer considerably. Some varieties of peaches are more disagreeable to work among than others. The condition of the atmosphere is also a factor in the case. After a rain, and on cool, windy days, the fuzz does not cause much inconvenience.

But high temperature, high relative humidity and dry weather favor it. Workmen are affected on and off throughout the peach season, but old hands become more or less immune against the disease. Peach fever is not contagious, and, so far, I have not been able to isolate a specific microbe.

Query: Might not the, as yet, undiscovered germs of both peach fever and peach yellows turn out to be identical?

As we were with reluctance forced to acknowledge the identical causation of certain human and brute diseases, so we may be compelled, finally, to admit that the same cause may give rise to disease alike in the animal and in the vegetable.

In closing, I wish to beg pardon for inflicting a new disease on the people, and for adding another title to the already complex nosology of disease.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JANUARY 6, 1893.

The 274th regular meeting was called to order by the President, Dr. Wm. E. Moseley.

Drs. Richard F. Gundry, of Catonsville, Delano Ames and J. D. Farrar, of Baltimore, were elected members.

Dr. N. G. Keirle exhibited a rabbit into which he had inserted the virus of rabies. On the 27th of November, a Baltimore policeman was severely bitten on the hand and in the thigh by a dog that attacked him. The dog was subse-

quently killed and the policeman underwent a course of treatment at the Pasteur Institute in New York. A post-mortem was made on the dog on the night of the 27th. The cord was removed and sent to the John Hopkins Hospital, where Dr. Nuttall the next day inoculated two rabbits. Dr. Keirle then took the cord to his laboratory in the College of Physicians and Surgeons, where he trephined a rabbit and inserted portions of the cord. On the 15th day thereafter the rabbit was sick. He had a very characteristic feature, namely, the gritting of the teeth. The next day it was very sick and lay upon its side, which is not natural with these animals, as they squat. It subsequently began to develop convulsions and the temperature dropped very low. The rabbit died on the 17th of December, and its spinal cord was used to inoculate the rabbit exhibited before the Society. The rabbit was trephined and a portion of the cord not larger than the smallest shot was put under the dura. It is now 20 days since the inoculation. There appears to be nothing much the matter with the animal, but it has grinding and gritting of the teeth, with occasional tremors over the face, amounting at times to slight convulsions. Dr. Keirle believed that in another day it would be much worse and in two or three days it would be dead. Further developments will be reported to the Society.

Dr. Harry Friedenwald read a letter received from his brother in Berlin, giving an interesting account of "Pettenkoffer and the Cholera Question."

The appointed subject for the evening was ANÆSTHETICS (CHLOROFORM versus ETHER). (See JOURNAL, January 21, page 265.)

Dr. L. McLane Tiffany objected to the phrase "chloroform versus ether." In the use of anæsthetics we are not confined to and ought not to be confined to chloroform or ether, neither should the two drugs be placed in opposition; they each have their place. We have in nitrous oxide gas a valuable anæsthetic for certain small operations. Dr. Tiffany in such cases meets his patient at the dentist's office, where gas is administered and the operation performed. The opening of an abscess, the releasing of a phimosis, the evulsion of a nail and other minor operations can be done under gas.

The respiratory organs and the kidneys are the two organs which are more concerned in the choice between ether and chloroform than any other. Dr. Tiffany prefers not to give ether when there is any tendency to pulmonary congestion. He gives chloroform in young children and in plethoric people on account of their tendency to bronchitis when ether is given. In phthisis he prefers chloroform. In pleuritic effusions he uses either anæsthetic. In aged people and people of flabby fiber he prefers chloroform.

We are generally led to believe, by the literature of the day, that ether is not to be given in cases of kidney disease. Dr. Tiffany knows of no certain evidence bearing upon this fact. He has operated several times in exstrophy of the bladder in which the ureters were exposed, using ether as the anæsthetic. He has never failed to see the urine flowing during the operation in undiminished amount. In operations upon the kidney he has in every case used ether and has seen no evil result. In a large number of railway accidents there will be found albumin in the urine and Dr. Tiffany has never seen any bad results from the use of ether in such cases.

There are certainly cases where ether, while perhaps better than chloroform, should be given with extreme circumspection. These are cases of injury where the patient has reacted and has come out of the shock due to the injury and is then submitted to the surgeon's knife. In these cases if the operation is long contiued the patient is apt to die in a certain number of hours afterward. Ether

should be given in minimum amount in these cases, and the operation done with extreme rapidity. A careful methodical operation under ether is very often followed by the death of the patient. He has given chloroform in some of these cases, but has made his patient pretty drunk before giving it. He operates upon a drunken rather than upon an anæsthetized man.

Dr. J. W. Chambers thought that the matter of giving ether or chloroform is largely a matter of habit. We say of a man that he is either a chloroformist or an etherite, according to his habit. Whether it is ether or chloroform it destroys probably all the centres except the respiratory and circulatory centres and now and then it destroys one of these. It seems not to matter much which we use. The etherite has one advantage over the chloroformist in that his patients die from pneumonia or suppression of urine while the chloroformist's patients die on the table from shock, hæmorrhage or chloroform.

Old people, young people, people with bronchitis, with kidney disease, women in obstetrics, etc., should preferably be given chloroform. If you remove these cases from the list of surgical operations you remove the greater number of the operations and this would seem to give the advantage to chloroform. In operation about the neck or head or in localities where venous hæmorrhage is feared Dr. Chambers prefers chloroform. Where a patient must be operated upon soon after a full meal chloroform is less likely to cause vomiting than ether. A case of death coming under Dr. Chambers' observation was that of a lady about 51 years of age to be operated upon for carcinoma of the breast. She was prepared for the operation and chloroform anæsthesia was begun. She had been given a glass of whiskey beforehand. She was asked to take two or three deep breaths; then the cylinder of chloroform was applied. She took a long breath, then a second, and then stopped. Dr. Chambers was then called and found her pulse still beating and pupils contracted. Artificial respiration was tried and respiratory stimulants given but she never breathed any more notwithstanding that her pulse beat ½ a minute to 2 minutes afterwards. Another case which he had observed was that of a child about 12 years of age with hip-joint disease. Her general condition appeared good, her lungs and heart apparently all right. In the midst of the operation, which was in a very few mintues, she suddenly stopped breathing. Most men give ether where they think there will be a prolonged operation, because they think it perfectly safe in such cases. A patient should be kept under ether no longer than is necessary to do a reasonably rapid operation. There is danger in the over-deliberation that is constantly practised because the patient is not screaming with pain.

Dr. A. Friedenwald related three cases, one of apparent death from chloroform with recovery, another of death from ether and the third from chloroform. The first was a case operated on for cataract extracion. The patient was about forty years of age. Local anæsthetics were not then in use and chloroform was given. The operation was begun and the section made, when the patient stopped breathing and had no pulse. The usual manœuvres for resuscitation were tried without avail and the man was concluded to be dead. After the lapse of several minutes Dr. Friedenwald in desperation gave the man a terrible thrust in his sides and immediately be began to breathe and his pulse to beat. Both centres in this case appeared to be overcome at once.

The case of death from ether was of a man about 82 years of age. He had some trouble in his abdomen and a lump was observed in the groin. A surgeon was called in and thought that the lump was not a hernia, but he could not be

certain unless an incision was made. As the incision would do no harm and might save life if the trouble was due to hernia, Dr. Friedenwald gave his consent to the operation. Ether was given, the incision was made and the lump found to be a hæmatocele. For about half an hour after the operation everything seemed to be all right and then breathing became affected. There were symptoms of congestion of the lungs and the man died in about thirty-six hours.

The third case was that of a girl 14 years of age. She came to the City Hospital six or eight weeks ago with granular ophthalmia and was to be treated by the mechanical method, with the roller forceps. She was given chloroform carefully with a large cylinder. After two or three inspirations there was a certain rigidity of the muscles and a peculiar blueness about the eye and the skin below the lower eyelids. The pulse was gone but the respiration continued for some time. When the respiration ceased artificial respiration was tried and also other means and finally the trachea was opened and air blown into the lungs, but without avail.

If the truth was known considerable of the popularity of ether would be lost. A great many deaths from ether doubtless occur which are never put down to its account but are charged to some supervening disease, such as congestion of the lungs, pneumonia, etc. If all of these cases should be collected perhaps as large a death rate from ether could be shown as that attributed to chloroform.

Dr. J. M. T. Finney spoke of the importance of the manner in which the anæsthetics are given. There is a great unanimity as to how chloroform should be given—that the vapor should be well diluted. As to the administration of ether Dr. Finney thought that not one patient is a dozen who are etherized is etherized properly. The etherizer usually fills the cone with ether, claps it on the patient's face and keeps it there. The patient under these conditions has a spasm of the glottis, will cough, get blue and will do all sorts of things which he will not do if ether is given properly. Dr. Finney prefers newspapers, wrapped up in a towel and formed into a cone with a piece of cotton or sponge in the apex, to any of the inhalers on the market. What is wanted is plenty of air and plenty of ether. The patient should go under ether as quietly and as quickly in a majority of cases as under chloroform. At first a half teaspoonful of ether should be put in the cone, say every half minute, and the cone put carefully over the patient's nose. By starting in gradually you gain the patient's confidence and he will do what you tell him. He will soon begin breathing mechanically and if you tell him to breathe as you do he will follow you, mechanically. The most important point of all is the one which is usually disregarded and that is the keeping of the air passages free from mucus and vomitus. The patient's mouth should be kept open, the head on one side and drawn well forward below the rest of the body, so that the mucus will run out by gravity over the hand of the etherizer. The patient's mouth should be swabbed out very frequently as far down as the fauces. If this point is carefully regarded the deaths from ether will be very much diminished.

As we get more data on this subject, the number of contraindications for ether in the way of kidney diseases, lung and heart affections, will doubtless diminish. Dr. Finney could not recall a case of suppression of urine after ether. He had used and seen ether used in children with very good results and had seen a death of a child from chloroform and two instances in which children almost died from chloroform.

Dr. Finney at one time used chloroform pretty generally, but his experience

has made him an etherite. He believes that the time is coming and is not far distant when the administration of chloroform will not be considered justifiable by the profession except in some selected cases.

Dr. J. D. Blake believed that we were narrowed down to one or the other anæsthetic that chloroform would be found to give the best results in the long run. He did not agree with Dr. Finney that chloroform would soon be discarded. He believed with Dr. Finney that there is a great deal in the method of preparing the patient and of giving the anæsthetic. Three or four hours before the operation five or six grains of quinine and ¼ grain of morphia, if there is a good heart, should be given. If there is any doubt about the character of the heart, digitalis should be added to this combination. After this preparation the patient will stand chloroform well and rally from it promptly. It is also advisable in many cases where you have a weak heart, and especially in railroad injuries, to use stimulants. Having prepared the patient, the next thing is to properly give the anæsthetic.

Neither ether nor chloroform should be given in a saturated form from the beginning. Many of the deaths are probably due to the method of administration rather than to the drug. The patient should be allowed to gradually inhale the anæsthetic, and then after the first stage is over you can push to complete anæsthesia.

Dr. Blake has never had any fatal results from ether, but he has had at times to stop the operation and look after the respiratory organs of the patient. Sometimes with the struggling it is difficult to keep the mouth-gag in, and it is hard to open the mouth to clean it out. Death is probably often due to the impurity of the anæsthetic. Very few doctors are perfectly sure that they are using a pure drug. Ether can be tested by a few drops of balsam of copaiba. If it makes a clear solution it is a chemically pure ether, but if cloudy it contains alcohol or water.

Dr. Blake carries both ether and chloroform in his satchel and uses them according to the indications and not according to habit.

1519 N. Broadway. W. T. Watson, M. D., Secretary.

DOG FLESH AS AN ARTICLE OF DIET.

An official document recently published by the municipal authorities of Munich gives some startling information as to the increased consumption in that city of dog flesh, an article of diet which has hitherto found most favor in the eyes of inhabitants of the Celestial Empire. So great an appetite do the denizens of the Bavarian capital seem to have developed for that "strange food" that the authorities have thought it time to interfere for the protection of dog owners, whose pets are stolen to grace the table of the intrepid *gourmets* who lust after canine flesh pots. This new form of poaching has, it appears, grown into a regular industry in Munich, the demand creating the supply in accordance with economic laws. Dog flesh is largely consumed as such by Italian workmen, thousands of whom are employed in Munich, but there is also too much reason to believe that the same substance is as freely used in the concoction of sausages in that city as the flesh of the harmless necessary cat is supposed to be used nearer home.—*Ex.*

A Paris journal defines restaurant coffee as a mixture of roasted horse-liver, black-walnut saw-dust and caramel.—*Amer. Lancet.*

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A. K. BOND, M. D., Editor.

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BALTIMORE, FEBRUARY 18, 1893.

Editorial.

THE NATIONAL QUARANTINE BILL.

Having just received from Dr. G. Lane Taneyhill, Secretary of the State Medical Faculty, a draft of the National Quarantine Bill sent him by our representative in Congress, the Hon. Isidor Rayner, to whom we are largely indebted for the passage of the same by Congress, we give the text in full, as it passed both Houses, for the benefit of the many physicians who are interested in the safety of our nation. The bill was introduced in the Senate by Mr. Harris, and passed. Despairing of securing the passage of a better one at this session, the House, upon motion of Mr. Rayner, concurred in the Senate bill on Feb. 8th. It still needs the signature of the President, but this will without doubt be given, as the Harris bill is a welcome advance upon the existing laws.

An act granting additional quarantine powers and imposing additional duties upon the Marine Hospital Service:

Be it enacted by the Senate and House of Representatives of the United States in Congress assembled.

Section 1. That it shall be unlawful for any merchant ship or other vessel from any foreign port or place to enter any port of the United States except in accordance with the provisions of this act and with such rules and regulations of State and municipal health authorities as may be made in pursuance of, or consistent with, this act; and any such vessel which shall enter, or attempt to enter, a port of the United States in violation thereof shall forfeit to the United States a sum, to be awarded in the discretion of the court, not exceeding $5.000, which shall be a lien upon said vessel, to be recovered by proceedings in the proper district court of the United States. In all such proceedings the United States district attorney for such district shall appear on behalf of the United States; and all such proceedings shall be conducted in accordance with the rules

and laws governing cases of seizure of vessels for violation of the revenue laws of the United States.

Section 2. That any vessel at any foreign port, clearing for any port or place in the United States, shall be required to obtain from the consul, vice-consul or other consular officer of the United States at the port of departure, or from the medical officer where such officer has been detailed by the President for that purpose, a bill of health, in duplicate, in the form prescribed by the Secretary of the Treasury, setting forth the sanitary history and condition of said vessel, and that it has in all respects complied with the rules and regulations in such cases prescribed for securing the best sanitary condition of the vessel, its cargo, passengers and crew; and said consular or medical officer is required, before granting such duplicate bill of health, to be satisfied that the matters and things therein stated are true; and, for his services in that behalf, he shall be entitled to demand and receive such fees as shall by lawful regulation be allowed, to be accounted for as required in other cases.

The President, in his discretion, is authorized to detail any medical officer of the government to serve in the office of the consul at any foreign port for the purpose of furnishing information and making inspection and giving the bills of health hereinbefore mentioned. Any vessel clearing and sailing from any such port without such bill of health, and entering any port of the United States, shall forfeit to the United States not more than $5,000, the amount to be determined by the court, which shall be a lien on the same, to be recovered by proceedings in the proper district court of the United States. In all such proceedings, the United States district attorneys shall appear on behalf of the United States; and all such proceedings shall be conducted in accordance with the rules and laws governing cases of seizure of vessels for violation of the revenue laws of the United States.

Section 3. That the Supervising Surgeon General of the Marine Hospital Service shall, immediately after this act takes effect, examine the quarantine regulations of all State and municipal boards of health, and shall, under the direction of the Secretary of the Treasury, co-operate with and aid State and municipal boards of health in the execution and enforcement of the rules and regulations of such boards, and in the execution and enforcement of the rules and regulations made by the Secretary of the Treasury to prevent the introduction of contagious or infectious disease into the United States from foreign countries, and into one State or territory or the District of Columbia, from another State or territory or the District of Columbia; and all rules and regulations made by the Secretary of the Treasury shall operate uniformly and in no manner discriminate against any port or place. And at such ports and places within the United States as have no quarantine regulations under State or municipal authority, where such regulations are, in the opinion of the Secretary of the Treasury, necessary to prevent the introduction of contagious or infectious disease into the United States from foreign countries, or into one State or territory or the District

of Columbia, from anothor State or territory or the District of Columbia, and at such ports and places within the United States, where quarantine regulations exist under the authority of the State or municipality, which, in the opinion of the Secretary of the Treasury, are not sufficient to prevent the introduction of such diseases into the United States, or into one State or territory or the District of Columbia, from another State or territory or the District of Columbia, the Secretary of the Treasury shall, if in his judgment it is necessary and proper, make such additional rules and regulations as are necessary to prevent the introduction of such diseases into the United States from foreign countries, or into one State or territory or the District of Columbia from another State or territory or the District of Columbia, and when said rules and regulations have been made, they shall be promulgated by the Secretary of the Treasury, and enforced by the sanitary authorities of the States and municipalities, where the State or municipal health authorities will undertake to execute and enforce them; but if the State or municipal authorities shall fail or refuse to enforce said rules and regulations, the President shall execute and enforce the same, and adopt such measures as in his judgment shall be necessary to prevent the introduction or spread of such diseases, and may detail or appoint officers for that purpose.

The Secretary of the Treasury shall make such rules and regulations as are necessary to be observed by vessels at the port of departure and on the voyage, where such vessels sail from any foreign port or place to any port or place in the United States, to secure the best sanitary condition of such vessel, her cargo, passengers and crew; which shall be published and communicated to, and enforced by the consular officers of the United States. None of the penalties herein imposed shall attach to any vessel, or owner, or officer thereof until a copy of this act, with the rules and regulations made in pursuance thereof, has been posted up in the office of the consul or other consular officer of the United States for ten days, in the port from which said vessel sailed; and the certificate of said consul or consular officer, over his official signature, shall be competent evidence of such posting in any court of the United States.

Section 4. That it shall be the duty of the Supervising Surgeon General of the Marine Hospital service, under the direction of the Secretary of the Treasury, to perform all the duties in respect to quarantine and quarantine regulations which are provided for by this act, and to obtain information of the sanitary condition of foreign ports and places from which contagious and infectious diseases are or may be imported into the United States, and to this end the consular officers of the United States at such ports and places as shall be designated by the Secretary of the Treasury shall make to the Secretary weekly reports of the sanitary condition of the ports and places at which they are respectively stationed, according to such forms as the Secretary of the Treasury shall prescribe, and the Secretary of the Treasury shall also obtain, through all sources accessible, including State and municipal sanitary authorities throughout the United States, weekly reports of the sanitary condition of the ports and places within the United States, and

shall prepare, publish and transmit, to collectors of customs and State and municipal health officers and other sanitarians weekly abstracts of the consular sanitary reports and other pertinent information received by him, and shall also, as far as he may be able, by means of the voluntary co-operation of State and municipal authorities of public associations and of private persons, procure information relating to the climatic and other conditions affecting the public health, and shall make an annual report of his operations to Congress, with such recommendations as he may deem important to the public interests.

Section 5. That the Secretary of the Treasury shall from time to time issue to the consular officers of the United States, and to the medical officers serving at any foreign port, and otherwise make publicly known the rules and regulations made by him, to be used and complied with by vessels in foreign ports, for securing the best sanitary condition of such vessels, their cargo, passengers and crew, before their departure for any port in the United States, and in the course of the voyage, and all other such rules and regulations as shall be observed in the inspection of the same on arrival thereof at any quarantine station at the port of destination, and for the disinfection and isolation of the same, and the treatment of cargo and persons on board, so as to prevent the introduction of cholera, yellow fever, or other contagious or infectious diseases; and it shall not be lawful for any vessel to enter said port to discharge its cargo, or land its passengers, except upon a certificate of the health officer at such quarantine station certifying that said rules and regulations have in all respects been observed and complied with, as well on his part as on the part of the said vessel and its master, in respect to the same and its cargo, passengers and crew; and the master of every such vessel shall produce and deliver to the collector of customs at said port of entry, together with the other papers of the vessel, the said bills of health required to be obtained at the port of departure, and the certificate herein required to be obtained from the health officer at the port of entry; and that the bills of health herein prescribed shall be considered as part of the ship's papers, and when duly certified to by the proper consular or other officer of the United States over his official signature and seal, shall be accepted as evidence of the statements therein contained in any court in the United States.

Section 6. That on the arrival of an infected vessel at any port not provided with proper facilities for the treatment of the same, the Secretary of the Treasury may remand said vessel at its own expense to the nearest national or other quarantine station, where accommodations and appliances are provided for the necessary disinfection and treatment of the vessel, passengers and cargo; and after treatment of any infected vessel at a national quarantine station, and after certificate shall have been given by the United States quarantine officers at said station, that the vessel, cargo and passengers are each and all free from infectious disease or danger of conveying the same, said vessel shall be admitted to entry at any port of the United States named within the certificate. But at any ports where sufficient quarantine provision has been made by State or local author-

ities, the Secretary of the Treasury may direct vessels bound for said ports to undergo quarantine at said State or local station.

Section 7. That whenever it shall be shown to the satisfaction of the President that, by reason of the existence of cholera or other infectious or contagious diseases in a foreign country, there is serious danger of the introduction of the same into the United States, and that, notwithstanding the quarantine defense, this danger is so increased by the introduction of persons or property from such country that a suspension of the right to introduce the same is demanded in the interest of the public health, the President shall have power to prohibit, in whole or in part, the introduction of persons and property from such countries or places as he shall designate, and for such period of time as he may deem necessary.

Section 8. That whenever the proper authorities of a State shall surrender to the United States the use of the buildings and disinfecting apparatus of a State quarantine station, the Secretary of the Treasury shall be authorised to receive them and pay a reasonable compensation to the State for their use, if, in his opinion, they are necessary for the United States.

Section 9. That the act entitled "An act to prevent the introduction of infectious or contagious diseases in the United States and to establish a national board of health," approved March 3, 1879, be, and the same is hereby, repealed, and the Secretary of the Treasury is directed to obtain possession of any property, furniture, books, paper, or records belonging to the United States which are not in possession of an officer of the United States under the Treasury Department which were formerly in the use of the national board of health, or any officer or employee thereof.

Recommendations of Therapeutic Agents.

Important information regarding Glycozone.—Glycozone is a staple compound resulting from the chemical reaction which takes place when C. P. glycerine is submitted, under special conditions, to the action of fifteen times its own volume of ozone, under normal atmospheric pressure at a temperature of O° C. The presence of water (and other foreign substances) in the glycerine, changes the nature of this reaction, so that instead of producing glycozone, we obtain formic acid, glyceric acid, and other secondary products having deleterious effects upon the animal cells. Glycozone being hydroscopic, must be tightly corked, so as to avoid being deteriorated by the moisture contained in the atmosphere. Although glycozone absorbs water readily, it does not deteriorate when kept at a temperature of 110 degrees F., as long as it retains its proper anhydrous condition. The therapeutic properties of glycozone and Marchand's peroxide of hydrogen (medicinal) differ in the following particulars: Peroxide of hydrogen (medicinal) instantly destroys the morbid elements of diseased surfaces of the skin or of the mucous membrane with which it comes in contact, leaving the tissues beneath in a healthy condition. On the contrary, glycozone acts more slowly, but not less certainly as a stimulant to healthy granulations. Its healing action upon diseased mucous membrane is powerful and

harmless in the treatment of inflammatory diseases of the stomach. In such cases it gives an immediate relief to the patient. (See Dyspepsia, page 27.) In chronic inflammation of the intestines, a rectal injection administered every day with a mixture composed of Glycozone ℥1, lukewarm water ℥12, soon relieves obstinate conditions. A syringe made exclusively of hard rubber or glass should be used in all instances where either peroxide of hydrogen (medicinal) or glycozone is used as an enema. After any diseased or suppurating surface has been cleansed by peroxide of hydrogen (medicinal), the application of glycozone stimulates healthy action, and accelerates a cure.

General directions for use: Glycozone may be given for diseases of the stomach, in doses of one to two teaspoonfuls in a wine-glassful of water immediately after each meal. In catarrhal diseases, it should be applied in full strength as often as required.

As an application to wounds and suppuratig surfaces it should be used without dilution.

Glycozone is a peculiar chemical compound, and not a mixture of peroxide of hydrogen (medicinal) with glycerine. These two liquids when mixed do not form a stable product, but develop substances which have injurious effects upon animal cells. Such a mixture when freshly made has no healing properties similar to glycozone. On the contrary, glycozone is stable, harmless and always effective.

Medical Items.

A Georgia Editor Wants His Money.—The following is from the pen of a Georgia editor who evidently had strong feelings on the subject: "The wind bloweth, the water floweth, the farmer soweth, the subscriber oweth, and the Lord knoweth that we are in need of our dues. So come a-runnin' ere we go a-gunnin'; we're not funnin'; this thing of dunnin' gives us the blues."—*Baltimore Sun.*

The above are our sentiments. Will our subscribers please comply?

The Southern Medical Record states that Atlanta will soon have a Post-Graduate Medical School for clinical instructions. It will be known as the Atlanta Polyclinic. It will open March 15th, 1893, for entire year.

Dr. J. Edwin Michael, formerly editor of this Journal, delivered the first of a series of lectures, Tuesday night, on "First Aid to the Injured," at the rooms of the Pennsylvania branch of the Y. M. C. A., on North Ave. Dr. Michael entertained quite a number of the employees of the P. R. R. Co., including several of the officers.

At a meeting of the last Legislature an act was passed regulating the practice of medicine and establishing a Medical Board of Examiners to enforce it. Out of the six men who have been appointed, Governor Thomas has given the regular profession four members, the homœopaths and eclectics, one each, leaving one vacancy. The law under these men will be rigidly enforced, and quackery, which has been rather dominant, will receive its deserved blow.—*Charlotte Medical Rec.*

In some of the cities of England the need for public urinals on the streets of the business section is met by the construction of lavatories and waterclosets under the pavements. The underground chambers built in Paris, one for each sex,

are the property of the city and are kept scrupulously clean and free from odor. A small charge is made for their use. It is said that the public look upon them as a great boon.

The Section of Hygiene of the Berlin Teachers' Association has passed a resolution that it is desirable that a committee of medical men, public officials, architects, engineers, school-managers and teachers should be formed to investigate the sanitary condition of Berlin schools, with a view to carrying out of whatever improvements may seem necessary. The resolution further declares it to be desirable that provision should be made for the inspection of schools by medical men.—*Ex.*

At a recent session of the New York Pathological Society, Dr. Northrup exhibited the brain and spinal cord from a case of cerebro-spinal meningitis in a child something over three years old. The child was convalescing from measles when one day she was taken with a chill, vomiting and then high fever. The head became retracted in a few days, the back of the neck was tender, she had a shrill cry; there was present shortly twitching of the face, divergent strabismus and increasing stupor. The temperature rose to 108°.6 Fahr., before death. The peculiarities in the case were that there were no convulsions, no paralysis, no opisthotonos and no eruption. The post-mortem findings were also unusual. The brain ventricles were greatly dilated and the inflammation of the ependyma very marked. In places there were some purulent exudate. Along the posterior surface of the spinal cord there was a heavy layer of inflammatory exudate.—*Exchange.*

A year's study at Gizeh has convinced Mr. Flinders Petrie that the Egyptian stone-workers of 4,000 years ago had a surprising acquaintance with what have been considered modern tools. Among the many tools used by the pyramid-builders were both solid and tubular drills and straight and circular saws. The drills, like those of to-day, were set with jewels (probably corundum, as the diamond was very scarce), and even lathe tools had such cutting edges.

So remarkable was the quality of the tubular drills and the skill of the workmen that the cutting marks in hard granite give no indication of wear of the tool, while a cut of a-tenth of an inch was made in the hardest rock at each revolution, and a hole through both the hardest and softest material was bored perfectly smooth and uniform throughout. Of the material and method of making the tools nothing is known.—*Amer. Jour. Dental Science.*

The Shah of Persia seems anxious to do everything in his power to arrest the epidemic of cholera which is still active in various parts of the country. Having been struck with the danger which is involved in the prevalent practice of exhuming the dead for subsequent burial in holy places, he has recently issued an order forbidding further exhumations in the future. The amusing part of it, however, lies in the fact that he has been the first to break the law laid down by himself. One of his wives died some time ago and was buried within her son's palace. The young prince who was then absent from Teheran is now on the point of returning to the capital and as the Persians believe that it is of evil omen to dwell too near the dead, he is anxious to have his mother's remains removed to Meshed. This, however, the Shah's ministers have declined to permit. The Sovereign to whom the matter was referred has decided that the body will be exhumed, but with all necessary precautions, including a free use of carbolic acid.—*Exchange.*

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Original Articles.

THE PSYCHOTHERAPIC TREATMENT OF MORPHINISM.

BY DR. EDGAR BERILLON, OF PARIS,
Editor "*Revue de l'Hypnotism.*"

TRANSLATED FROM THE FRENCH BY DR. HERBERT ADAMS, BERLIN,
Late Assistant Physician "Brooklyn Home for Habitues;" Member "Société d'Hypnologie et de Psychologie" de Paris.

The question of morphinism is justly seriously occupying the minds of physicians and psychologists.

This new form of intoxication has, during the past few years, made such rapid progress, that many authors do not hesitate to signal it as a veritable social danger. It seems to us, however, that the gravity of the evil lies not so much in its rapid extension to all classes, as its frequent development among the intellectual class. If one should make a list of all the great minds, savants, physicians, litterateurs and artists, who have become addicted to this most tyrannical of all drugs, one would be surprised at its length; nor would the astonishment be less from a knowledge of the names of well-known men whose brilliant careers have been brusquely arrested and their moral and intellectual value entirely ruined by this evil.

It is necessary to recognize that it is, above all, among the intellectual classes that pain, both physical and mental, is the most dreaded; this explains the facility with which many persons have recourse to morphine to relieve them of sufferings

judged by them intolerable. Nearly all the morphinists that we have had occasion to observe had first accepted with gratitude the assistance of this marvelous anæsthetic. None of them suspected the rapidity with which the "besoin morphinique" establishes itself, and the disease was formed, in the majority of cases, so insidiously that they did not realize or distinguish the difference between the sufferings due to abstinence and those for which they had first taken the drug.

This confusion often constitutes the first difficulty that one meets when it comes to inaugurating the treatment. The patient rarely fails to invoke the following argument: "Who can promise me that, when I have abandoned the morphine, I shall not again have my former sufferings?" This difficulty is not the only one. Under the influence of his intoxication, the morphinist soon presents psychic troubles the most varied. Of all the functions, that of sleep is the most profoundly affected. If morphine favors sleep in the beginning, it very soon, on the contrary, engenders the most rebellious nocturnal insomnia. The patient, not able to sleep at night, frequently becomes a noctambul, while often, during the greater part of the day, he may rest as an inert mass, incapable of thinking, moving or acting. He has not force of will to rise from bed and, fortune permitting, he soon forms the habit of passing here the greater part of the day. According as he is, or is not, under the influence of his injections, he passes from one extreme to another of profound anæsthesia or hyperæsthesia in which the entire nervous system participates. If at certain moments he is indifferent to everything, deprived of his initiative, a prey to horrible dreams, at others, when under the influence of a recent injection, he is brilliant, animated and capable of making a certain figure in the world, or of applying himself to his ordinary occupations. It seems to him as if he were infused by his injection as with an elixir of life. But the duration of the period of animation tends more and more to shorten itself. Very soon the fictitious excitation created by the injection passes away and sensations the most normal are painfully felt again. As soon as the crisis of abstinence develops itself, the sufferings assume such an acute type that the patient will neglect nothing to prevent their return. It is then that we may observe with great distinctness the moral and psychic side of the malady and observe the apparition of the singular phenomena of auto-suggestion. Demoralized by the fear of suffering, the morphinist exaggerates unconsciously the painful effects of the suppression of the morphine. He is a prey to a veritable *hyperæsthesia auto-suggested.* Under these conditions it is not at all surprising that he should subordinate all his actions to his desire to avoid the pains, the mere thought of which determine in him a profound moral depression.

Morphinism is then primarily an intoxication; secondarily it becomes a veritable disease "de l'esprit," the effects of which manifest themselves above all by an alteration of the principal faculty: the *will.* That is to say, that all therapeutics not based on a thorough observation of the mental condition of the patient will be doomed to failure.

That which essentially characterizes the psychic state of the morphinist is the paralysis, the anæsthesia of the *will*. If the most of his intellectual faculties have remained intact, if his imagination has survived and even in certain cases is exalted, his initiative, on the contrary, is abolished. Nothing strikes the observer more than the want of decision, the irresolution which the patient manifests, and above all when it relates to his taking steps to inaugurate the treatment of his habit.

One of the illusions to which we cling the strongest is that of our free *will*. The morphinist is not deprived of this. The illusion which he caresses the longest is that he will be able to give up his morphine when he wishes to. To justify his continuation he furnishes himself with the most specious arguments, to such a degree that he felicitates himself on the services which it renders him, when he has need to act or work, not wishing to admit to himself the exaggerated price he pays for them. In short, the morphinist is above all a victim to paralysis of the will. Let us add to this, that he is rarely free from the two neuroses which exercise the most depressing action on the moral energy, hysteria and neurasthenia, not to speak of the nicotinism and alcoholism so frequently observed in these patients, and one will be sensible of the inherent difficulties in all attempts at the treatment of morphinism.

However, notwithstanding their extraordinary irresolution, it frequently happens that, justly alarmed by the grave trouble to the nutrition, struck by the failure of their intellectual faculties, one of these patients decides to demand of medicine to cure him of a disease which she has nearly always caused. He then receives the advice to isolate himself, for a short while, in a sanitarium.

Advice, in itself, is good, but it has little chance of being listened to and followed. Very few morphinists, in fact, will make such a confession of their impuissance. The majority of them devoting themselves to diverse labors, most often to scientific, literary or artistic, which they are able to continue, thanks to the increasing doses of their habitual stimulant, do not wish to resign themselves to abandon their social situation nor the direction of their affairs. They dread the darts of public malignity, disposed to consider as an alien any person entering a sanitarium. In presence of the obstinate refusal of patients to submit to isolation, a certain number of physicians decided to try the employment of psychotherapy—that is to say, of suggestion during the hypnotic state, to arrive at a cure of morphinism.

In this respect the observations by MM. Burkhard, Wetterstrand,* Auguste Vaisin, Fonel, Blocq, Zambaco, Marselli and Garodichze are the most conclusive and the results obtained by them are of the nature to carry conviction. Having had, ourselves, occasion to apply suggestion in the treatment of morphinism, we believe the moment has come to point out the role that psychotherapy is destined

*Dr. Wetterstrand reports 22 cases treated by suggestion alone. In 19 cases the treatment was followed by complete success. Dr. Wetterstrand considers that this mode of treatment is going to cause complete revolution in the treatment of morphinomania. With several of his patients he had recourse to prolonged sleep during several weeks, with others the cure was effected much more rapidly.

to play. This role will be more extended from the fact that morphinists generally show themselves very amenable to suggestion when they have once determined to attempt a cure. The physician (and this is one point we judge useful to insist upon) should not commence the treatment until he is assured that he has acquired the absolute confidence of the patient. Much time and patience is often necessary to acquire the necessary influence on the patient to direct the treatment with authority. The facts show that a cure, although difficult, is not impossible to obtain. This is why we publish the resumè of some of our observations, which seem to us to contain certain teachings useful to retain.

Case I.—The first patient that we had occasion to treat, Mme. C., aged fifty-five, came in 1882 to demand the aid of hypnotic suggestion against the intolerable pains which she suffered in the left ovarian region. Some years before she had sustained a rather severe operation in this region, and it was during convalescence that she commenced, on the advice of her physician, the use of morphine. She walked with the trunk flexed at an angle of 45 and could not straighten herself except under the influence of injections of morphine, and even then there was considerable deformity of the spinal column and difficulty in walking. The general condition of the patient was extremely poor.

She did not come to ask for treatment of her disease, she was occupied only with the abdominal pains. We exhausted all our arguments, without success, to induce her to diminish the morphine, attributing to the phenomena of abstinence the periodic return of the pains. We then encountered the petition, that we have since heard from the majority of our patients, "Cure me first of my pains, then we will see about the other." I complied with her request and after a few séances she was profoundly affected. Incidentally, in suggesting to her to not feel again the pain, I also added in the suggestion that the morphine would certainly considerably shorten her life. This idea deposited in her mind soon took deep root, and some days afterwards she came spontaneously to ask my aid in the cure of her habit. She gave us the reason of her determination to cure herself, that she wished to live as long as she possibly could, for she knew her death would cause great joy to some of her heirs, "and if morphine is going to shorten my life I am going to quit it."

The treatment was commenced without any definite method. I confined myself to suggesting to her to guard the determination to cure herself promptly, to become very avaricious of the injections and to continue the suppression in spite of whatever sufferings might follow.

The patient was animated with such a desire to be cured that she suppressed the injections much more rapidly than I had thought of doing. In less than fifteen days, without the aid of any medicine whatever, by the sole power of will, seconded and stimulated by daily suggestions, she triumphed over the most cruel sufferings. It was possible by suggestion to greatly reduce the intensity of her sufferings, and in particular the profuse perspirations by which she was troubled for several months after the entire suppression.

The cure has been maintained for five years. She has told me that the argument which had a decisive action on her cure was the fear, suggested by me, of shortening her life.

Case II.—Mlle. B., thirty years of age, was an intelligent lady having decided, as "religieuse," on hospital service; having been expelled from the order on account of her drug-taking, she was sent to us by Dr. Gonel. She came to consult us on the 4th of February, 1890. Some years previously she had been attacked by intermittent facial neuralgia, for which she had been given hypodermics of morphia for two years (beginning with two per day and finishing with eight per day). During the year of 1887 she had multiple abscesses, for which she entered the "Beaujon Hospital." She was here treated by Drs. Milliard and Schwarz, who decided to suppress brusquely the morphine. She fell into a delirium which lasted some twenty days. She was in a state of great excitement, chanting day and night. When the delirium passed away she awoke completely well and the cure lasted for two years. The neuralgias returning eight months ago, she again began taking morphine and commenced with four injections daily.

The day she came to consult us her color was yellowish and cachetic. She suffered from gastric pains, her digestion was poor and painful, and she alternated with constipation and diarrhœa. For some time she had had terrible nightmares. The catamenia had been suppressed for some months. When the hour for her injection arrived, if she endeavored to retard it, she was seized with sudden vomiting, shiverings and diarrhœa. She had become melancholic and lived constantly preoccupied in thinking of the future. She took fifteen injections daily of 5 milligrammes each, making about 8 centigrammes for the twenty-four hours.

The treatment was commenced the 6th of February, 1890. It was decided that the patient should come and receive the suggestions daily and she should suppress one injection each day. She slept soundly from the first sèance. The 20th day, conforming to a suggestion made, she laid on my bureau her syringes and the remainder of the morphine. All the malaises with which she was troubled, such as diarrhœa, vomiting and profuse sweats, disappeared under the influence of suggestion. The catamenia returned. Two months afterwards the patient looked like another person.

The success of this cure was due in a great measure to the assistance of an infirmiére, Mrs. Rousseau, who assisted greatly by frequently massaging the patient and also sustaining her by her counsels, watching her carefully, etc. Eighteen months afterwards the cure continued.

Case III.—Mme. B., aged thirty-three, mother of four children, commenced taking morphine in 1884 on account of nephritic colic. Afterwards she took injections for the slightest neuralgias and more especially after the removal of a uterine polypus by Dr. Gonel, who advised the patient to consult us. She came the 3rd of July, 1890. Two years previously, having attempted to substitute cocaine for the morphine, she became quite seriously affected mentally, and es-

pecially by hallucinations. She entered the asylum at Charenton. Dr. Ritti suppressed radically the morphine. Having entered the 23rd of February, she left at the end of April, cured and in good general health. She weighed ninety-nine pounds on entering and one hundred and twenty-three on leaving the asylum. She remembers this treatment with terror, and wonders that she was not made permanently insane by it. The cure was of short duration. In September of the same year, being "enciente," her physician expressed a fear of the return of her polypus. On account of her despair at this intelligence she again commenced taking morphine, beginning with five injections daily. When she came to consult us, she was taking forty centigrammes daily. She made several injections without removing the needle, fearing the numerous punctures, as she had had, and had still, a certain number of abscesses. These, indeed, are what induced her to attempt a cure.

The patient passed her nights in reading; her books denoted a cultivated mind; she had read the works of all the well-known authors. She did not sleep before four or five o'clock in the morning and rose very late. She took no breakfast and often slept again in the afternoon. Her temper had become irritable and she was very unsociable.

The treatment commenced on the 3rd of July and was continued without interruption during one month. An extraordinary thing was that the patient came each day without a single exception for a consultation. It is but just, however, to add that she paid for the first month's treatment in advance; that had certainly a considerable influence on her perseverance. From the 6th of July, three days after the commencement of the treatment, she took only 20 centigrammes. The 16th of July she took only 3 centigrammes.

At each séance she was plunged into profound sleep with amnesia on awakening. She received the suggestion and made the injections only with extreme repugnance. In spite of the malaises which she experienced, vomiting, diarrhœa and profound sweats, she held fast.

The 24th of July she laid on my bureau her collection of syringes, conforming to a suggestion that I had made. She continued coming to demand my aid during some weeks on account of the malaise which she felt from time to time. She recovered her normal habits of sleep, her appetite, and she has an excellent general appearance.

Case IV.—The 1st of March, 1892, Pauline L., aged 26, came to my clinic complaining of rather serious nervous and mental troubles, hallucinations, nightmares, ideas of suicide, etc. She attributed these symptoms to the use of morphine. She entered the Charité in 1888 on account of some nervous trouble and was there treated with morphine. She took at the time of quitting the hospital one grain of morphine per day and continued taking that amount. A druggist, "a la conscience large," according to the expression of the patient, sold her as much as she wished at sixty cents a grain. She worked day and night to procure it, preferring to go without food rather than abstain from morphine. The appear-

ance of several abscesses induced her to try to diminish her dose, which she did, alone, to 50 centigrammes.

When she came to consult me she took 50 centigrammes daily, divided into eight injections. She had arrived at an extreme degree of enervation, the genital sense was entirely abolished, and the menstruation was almost entirely suppressed.

Being very hypnotizable the treatment was easy. A very curious thing was that she did not wish and could not be hypnotized, except by certain persons. The suggestion was made that she diminish one injection each day. At the end of four days, bilious vomiting having occurred, she increased a little. At the end of fifteen days she was taking only two injections daily.

To finish, I suggested to her that on arriving home she should throw away her solution and that after vainly trying to make an injection she should throw her syringe on the floor and stamp it under foot.

These suggestions were punctually carried out. For four days she remained in bed, having vomitings, diarrhœa and cold sweats; and demanding morphine from those around her. But her sister having been warned, saw that none was given her. The fifth day the malaise had disappeared and the patient felicitated herself upon having escaped from the habit. Since the first of April, 1892, she has not taken any morphine. She has moreover received energetic suggestion to resist all cravings which may occur. During the two following months she had very disagreeable sensations and fear of dying, and at certain moments a truly lamentable state of mind; but she hastened to come to demand the aid of suggestion and all her troubles vanished as if by enchantment.

I have been able to assure myself, beyond the peradventure of a doubt, that the patient is nearly well and takes no morphine.

Case V.—Mme. O., aged 26, in the course of a phlebitis complicated with a painful œdema extending to the thorax, commenced the use of morphine, which alone relieved her pains. The disease was rapidly formed, although she claims never to have experienced any pleasant sensations from the morphine beyond the mere calming of her pains. At the end of some weeks her physician allowed her to make the injections herself. She now takes eight centigrammes daily.

The treatment was commenced the 24th of May, 1892. From the first séances a manifest somnolence was obtained. She received the suggestion to repress, of herself, one injection. The same evening she did so and nevertheless passed a better night.

The next day she received the suggestion to suppress radically the injections of the next morning and to rise at eight o'clock without feeling the usual malaise. The suggestion was punctually followed and the patient passed a very agreeable morning, having risen at 8 o'clock. Very intelligently the patient seconded the treatment with enthusiasm and manifested the desire to cure herself very rapidly.

At the third séance she slept profoundly and received the suggeston to dine "en ville" in the evening without any previous injections and to bring me the

next day her solution, syringes, etc. At the appointed hour on the following day, she brought me her syringes and two bottles of morphine pellets, sold her by an unscrupulous druggist.

The effects of this sudden suppression promptly manifested themselves; during one month she was quite agitated and had spells of shivering and cold sweats. The day after her suppression she had a profuse diarrhœa; she vomited her dinner of the evening before and arrived at my office, worn-out, discouraged, and walking with difficulty. I put her profoundly to sleep. By suggestion, I dispelled her malaise and restored her courage; she left me quite gay, reanimated and determined to resist all temptations to take morphine. For some days she received the same suggestions. The cure has been maintained for six months and every indication points that it will be continued. During four months the patient came from time to time to demand the aid of suggestion.

This case is remarkable on account of the rapidity with which the suppression was effected. The rigorous adhesion to our usual method would have made the suppression more slowly, but we yielded to the pressing solicitations of the patient to finish with it at once. We must recognize that she showed a very uncommon force of will and was moreover endowed with remarkable intelligence and a very active mind. In this case, we had recourse to some physiological stimulants (digitalis, ext. coca) to compensate the brusque suppression, conforming ourselves, as we have always done under similar circumstances, to the precepts so justly formulated by Dr. Jennings.

In three other cases the treatment by suggestion was employed as an adjuvant to the treatment directed by our eminent confrére, Dr. Jennings, the competence of whom, in all matters relating to these questions, is so well-known. He has also recognized how much the phenomena of auto-suggestion dominate the situation and he proposes in a coming work to treat more fully of this, giving the results obtained. That which we should remember concerning the influence of suggestion in the treatment is, that it plays the principal role, first of all, in deciding the patient to begin treatment, then to awaken and stimulate his will-power and to give him a sufficient sum of energy, so that he will not be discouraged by the first uncomfortable feeling that he may experience.

We quickly come to the conclusion that the first few séances should be devoted to revivifying the failing will-power. The essential part of the treatment is, above all, to determine the patient to *will* to arrive at a complete cure, to exalt his desire to be free from his tyrannical drug. To make it odious to him and to make him give a proof of this, by taking the initiative in his treatment—in one word, to make of this the most active agent in the cure.

From our personal observation we believe ourselves able to deduce the following conclusions:

1st. If the distinction that writers have tried to establish between simple morphinism and morphinomania presents a certain interest from a clinical and medico-legal point of view, it offers only a secondary interest from a therapeutical stand point.

2nd. In both cases psychotherapy, that is to say, the employment of hypnotic suggestion, in the majority of instances; effects a complete cure without recourse to isolating patients in a special establishment.

3rd. In the cases where isolation is judged necessary, psychotherapy facilitates the treatment by diminishing very appreciably the pains and various troubles due to the abstinence.

4th. The difficulty in the demorphinization of a patient does not at all correspond with the mental troubles which he may present, nor with his poor physical condition at the moment of the commencement of the treatment. The difficulty results above all from the default of energy of the patient and his irresolution to cure himself.

5th. The duration of treatment is about one month. The morphine should be gradually suppressed. When the patient decreases to two or three centigrammes per day, the suppression should be radically made. At this time the suggestive séance should be repeated more often to combat the malaise and sustain the energy of the patient.

6th. The period of convalescence is less long when the suppression has been more slow. During some months after the total suppression, the malaises which frequently trouble the patient are easily dissipated by suggestion.

7th. The cures obtained by the employment and with the aid of suggestion are much more sure than those obtained by a forced suppression. They have for a base the awakening of the patient's will; and the putting into play of this will is the surest means of preventing a relapse; moreover, it is possible by suggestion to inspire in certain persons a positive disgust for morphine.

INTESTINAL ANTISEPSIS IN ENTERIC FEVER BY MEANS OF SUBIODIDE OF BISMUTH AND SALOL.

BY J. D. FARRAR, B. A., M. D., OF BALTIMORE.

Ex-Resident Physician to the Cooper Hospital, Camden, N. J., Out-Patient Surgical Staffs of the City and Child's Hospital.

Case I.—L. F., age 17, single, laundress, was admitted to the hospital October 2, 1891, suffering with diarrhœa, vertigo, disordered digestion, headache, epistaxis, disturbed sleep, depression and muscular weakness, followed by a chill. Previous to being admitted, the patient had six bowel movements during the 24 hours, with considerable pain in the abdomen. The movements were quite offensive and very dark. October 29, 1891, discharged cured.

Case II.—O. J., age 11, Swede, male, schoolboy, admitted October 17, 1891, suffering with anorexia, headache, vertigo, disordered digestion, disturbance during sleep, and muscular weakness. The tongue had the characteristic typhoid appearance, bowels were loose and quite offensive. He also had acute attack of laryngitis. Discharged cured December 1, 1891.

Case III.—W. T., age 36, male, married, shoemaker, admitted to the hospital October 25, 1891, complaining of dizziness, abdominal pains, muscular

weakness, diarrhœa, nausea, vomiting, soreness of lower extremities, bowels quite offensive, tongue characteristic typhoid appearance. Before being admitted to the hospital, had been treated for three weeks for malaria. November 30, 1891, discharged cured.

Case IV.—W. W., age 18, laborer, male, Ireland, single, came to the hospital, October 31, 1891, suffering with nausea, diarrhœa, anorexia, vomiting, epistaxis, muscular weakness, abdominal pains; tongue characteristic typhoid appearance; bowel movements were quite offensive and dark in character, had retention of urine for two weeks, when he had to be catheterized morning and afternoon. Before admission had been complaining of a tired feeling for two weeks. December 2, 1891, discharged cured.

Case V.—E. G., age 21, England, driver, single, male. This case was admitted to the hospital, November 7, 1891, suffering with a chill, high fever, diarrhœa, headache, epistaxis, anorexia, pain on micturition, abdominal tenderness, bowels quite offensive; was first taken sick three weeks before admission, but had only been confined to the bed three days when he was discharged cured on November 30, 1891.

Case VI.—C. W., age 19, single, male, N. J., laborer. When first taken sick he began to suffer with headache, diarrhœa, languid feeling, anorexia, abdominal pains; tongue showed characteristic typhoid appearance, bowel movements were quite offensive and frequent; discharged cured November 30, 1891.

Remarks.—The test of accomplishment of intestinal antisepsis is the deodorization of the stools. This method of treatment certainly seems to reduce tympanites, control diarrhœa, and prevent hæmorrhage, the latter complication being rare when the antisepsis is early secured and persistently maintained. This treatment will modify the severity if it does not limit the duration of the disease. Our rule is to begin the administration of the drugs mentioned alternately whenever diarrhœa exists, and to continue the same throughout the disease, aiming to keep the stools thoroughly disinfected. Twenty-four cases have been thus treated in the hospital, and the foregoing is the recommendation of the outcome of a study of the results thereby obtained given in five grain doses every three hours. The subiodide of bismuth to be given in a mixture containing simple syrup and elixir of cinchonæ and to be shaken up thoroughly before using.

As a result of an inquiry made by Dr. Le Dantec into the method employed by the natives of the New Hebrides in the manufacture of poisonous arrows, it appears that the aborigines of Australasia were the first and probably the only people to take advantage of the properties of certain bacteria in warlike purposes.

The point of the arrow is poisoned by dipping it into marsh mud which contains two virulent species of micro-organisms, viz., the vibrio Metschnikowii and the bacillus of tetanus. The former disappears if the arrows are exposed to the heat of the sun too long. Horses being unknown in the New Hebrides, the presence of the bacillus of tetanus in the soil of these islands goes rather against the theory that horses are the source of the disease.—*Medical Week.*

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BALTIMORE, FEBRUARY 25, 1893.

Editorial.

PROFITS AND LOSSES FROM PATENT MEDICINES.

For every successful venture in the patent medicine business, there are a dozen failures. This line of business may be more costly than gold mining, of which it has been said that "it costs a million to get a million out—as an average." The following cutting from a morning newspaper contains several grains of fact, along with several more grains of exaggeration:—

"A patent medicine that is retailed at $1 a bottle must not cost the manufacturer more than ten cents a bottle," declared the inventor of a medicine at a secret meeting of druggists the other day.

"If it does," he added, "the manufacturer won't make enough to maintain his family on. The druggist pays sixty cents for the preparation. That leaves an apparent margin of fifty cents a bottle to the producer. But at the start the advertising will cost him seventy-five cents a bottle, leaving a deficit of twenty-five cents. In other words, it costs about seventy-five cents to induce one man to buy his first bottle of a patent medicine.

"The profit lies in the fact that the man doesn't stop at the first bottle, but keeps on buying it and advising his friends to buy it. A medicine has to turn the corner, as it were, before producing it pays. Some of the concerns collapse while they're waiting for the citzen to buy his second bottle."

We fully believe that every "infant industry," which purposes to cure a multiplicity of human ills by making use of the newspapers, makes a loss on every first bottle that reaches the consumer. If subsequent bottles are purchased, then the profit begins to be attained.

MADAME BERNHARDT'S INVIGORATING LOTION.

The *Formulary* states that the great French actress makes very constant use of the following bathing liquid: spirit of ammonia and spirit of camphor, two

ounces of each, sea salt a cupful and a half, alcohol ten ounces. These ingredients are put in a quart bottle, which is next filled with boiling water; to be shaken before and while using. The actress is bathed from head to foot with this liquid, a sponge being employed; the body is then dried with slight friction with a fleecy towel. The effects of this procedure, in Madame Bernhardt's case, is to remove muscular soreness or stiffness and the sense of fatigue; the circulation is "trued up" and gentle languor induced, generally followed by somnolence. Such is the treatment upon which our modern Cleopatra relies, after the strain and exertion of her public performances. Whether other women can keep themselves unwrinkled and comely by the same means can only be demonstrated when they have experimented with the lotion with the same exactitude as has been done by this most laborious tragedienne. At all events, the latter appears fully to believe that the lotion—together with a rational personal hygiene persistently followed out from year to year—has been a balm of rejuvenation to her, that it has perpetuated her fresh looks and affords her an unfailing refreshment. She calls it her *eau sédative*, but by some others it is called "Bernhardt's balm."

Reviews, Books and Pamphlets.

Diseases of the Eye; by Hansell & Bell. P. Blackiston, Son & Co., Philadelphia.

In a little book of 223 pages, the authors have tried to give students and practitioners a reliable review of ophthalmology. Some parts of their work have been well done; some, in our opinion, have not. The description of the anatomy of the eye is good as far as it goes. Specially worthy of notice are the paragraphs on the ocular lymph system and the eye muscles. The description of the various forms of ametropia is brief, but clear. So, too, is the chapter on heterophoria. The conclusions concerning the clinical significance of this much-disputed condition (p. 88) seem to us excellent. Throughout, the book is well illustrated. In the preface, the authors say that no attempt has been made to treat the subjects exhaustively. In our opinion one fault runs through the whole book; in their desire for brevity, the authors have confined themselves almost entirely to their own opinions and methods. These are stated clearly; indeed, dogmatically. This is all right for class-room lectures or clinics to medical students; but it is out of place, we think, in a text-book. For instance, here is their explanation of the mechanism of accommodation (p.31): "By contraction of the *radiating fibres* of the ciliary muscle *toward their fixed points in the choroid*, the angle of the anterior chamber is drawn inward and backward, while the diameters of the lens are simultaneously shortened by the contraction of the circular fibres of the same muscle. The effect of this double contraction is to relax the suspensory ligament of the lens." (*Italics ours.*) If the authors really think this, it is all right to state it; but if one will take the trouble to consult books which have appeared during the past five or six years—Landolt, Swanzy, Volk, Noyes, de Schweinitz, Fuchs—he will find, we think, that while these authors substantially agree, the above does not express their teaching.

In the chapter on retinoscopy nothing is said of examination with the concave mirror. Nothing by way of treatment is suggested for "vernal" catarrh of the

conjunctiva. Jequirity, probably the most effective remedy we have for pannus resulting from trachoma, is not even mentioned.

The whole chapter on scarification of the conjunctiva in gonorrhœal ophthalmia is not spoken of, although swelling of this membrane as a symptom is mentioned. The authors, it is true, may believe in none of these things, but other writers of experience think they are of great importance. Certainly they deserve mention. If they are not considered as valuable as some suppose, they should be condemned. The chapter on conjunctival diseases seems to us inadequate; while all that is advised is good, important things are omitted, and no *reasons* are given for the recommendations which are made. The same thing is true to a greater or less extent of other chapters. The only operation for entropion which is given is "advancement of the tendon of the palpebral muscle." This has, the authors say, given them "the best results." The operation—not described in most of our larger works as a remedy for entropion—is here given only in the rarest outline, and the reader is left to conjecture why it is better than Green's, Snellen's, etc.

Throughout there is no effort apparent to train the judgment of the student or practitioner. It is just these little books which young general practitioners seek; and here they should find not alone dogmatic class-room statements, but some explanations of what they learned in the class-room. In this the book is a disappointment. Had it been fifty pages longer, it would have been made one hundred per cent. better.

Books and Pamphlets Received.

Arterial Saline Infusion; by Robert H. M. Dawbarn, M. D., of New York. Reprint from *Medical Record,* Nov. 12, 1892.

Report of a Case of Talipes Equino-Varus; by B. Merrill Ricketts, Ph.B., M. D., of Cincinnati. Reprint from *Journal American Medical Association,* Aug. 20, 1892.

Quarantine Control. State or National? the Question. A speech before the Chamber of Commerce and Industry of Louisiana; by Joseph Holt, M. D., of New Orleans. L. Graham & Son, 41 and 46 Baronne St., 1893.

Ueber das Volumen der rothen und weissen Blutkörperchen im Blute des gesunden und Kranken Menschen; by S. Judson Daland, Philadelphia. Reprint from *Fortschritte der Medecin.* No. 20, October 15, 1891.

A Clinical Study of Eleven Cases of Asiatic Cholera Treated by Hypodermoclysis and Enteroclysis; by Judson Daland, M. D., of Philadelphia. Reprint from *University Medical Magazine.*

Some Physiological Experiments with Magnets at the Edison Laboratory; by Frederick Peterson, M. D., and A. E. Kennelly. Reprint from *N. Y. Medical Journal,* December 31, 1892.

Fel Bovinum as a Therapeutic Agent; by D. H. Bergey, M. D. Reprint from *American Therapist,* January, 1893.

Abscess Around the Rectum; A Clinical Lecture; by Charles B. Kelsey, M. D. Reprint from the *Therapeutic Gazette,* January 16, 1893.

Seventh Annual Report of the Librarian of Enoch Pratt Free Library of Baltimore; January 1, 1893. John H. Shane & Co., 12 South St.

The Forthcoming Report of the Bureau of Education on "Professional Education in the United States"; by Bayard Holmes, M. D. Reprint from the *Journal of American Medical Association,* Jannary 14, 1893.

Prospectus of London Post-Graduate Course, Fourth Year, Spring Term, 1893;* Jonathan Hutchinson, F. R. S., President; J. Fletcher Little, M. B., Secretary; 60 Welbeck Street, Cavendish Square, London, W., to whom applications for cards of admission, and for any further information, should be addressed, and to whom all fees should be paid.

Official Directory of Hospitals and Asylums for the Insane in the State of New York. 1892: T. E. McGarr, Secretary, Capitol, Albany.

The Antiseptic Dropper; by GEORGE M. GOULD, M. D., of Philadelphia. Reprint from *Medical News*, December 3, 1892.

A Case of Homatropine Susceptibility; by GEORGE M. GOULD, M. D., of Philadelphia. Reprint from *Medical News*, January 21, 1893.

Amblyopiatrics; by GEORGE M. GOULD, M. D., of Philadelphia. Reprint from *Medical News*, December 31, 1892.

Medical Progress.

THE AMERICAN-BERLIN MEDICAL SOCIETY.

We have received from its first President, Dr. Judson Daland, through the *University Medical Magazine*, a short account of this useful Association, which was founded in Berlin, February, 1891.

This Medical Society does not neglect the social feature, as will be seen by the following record: On July 4 a stag dinner was given and thirteen members were present, and on July 23 a dinner was tendered the Society by the president; on July 30 the Society was given an onyx inkstand; on November 26 a Thanksgiving ball was given by the Society, and there were present 250 guests, many of whom were well known in German society as well as to the American colony, and there were present most of the well-known scientific men of Berlin. On February 22, 1892, Washington's Birthday was celebrated, in which seventy-five participated.

Dr. Edward Bush, Director of the Dental Institute of Berlin, was made an honorary member.

The present active membership number thirty-eight, and during the year over ninety names have been enrolled as members. The second year was most auspicious, and active interest was shown in the Society. The average attendance at each meeting varied from twenty-five to thirty. The thanks of the Society are especially due to the present president, Dr. W. D. Miller, of Berlin, and to its former and original secretary, Dr. F. A. Webber, now of Milwaukee.

This Society has increased in strength so that now it occupies an advanced position in Berlin, and all questions of great interest to the large American colony there are usually referred to it before action is taken.

In addition to the bi-monthly meetings, the members meet at regular periods for social entertainment. Further, this Society enables all the members to act in a body, so that special courses can be arranged with the *privat docents* and special rates obtained from instrument-makers and booksellers. A correct list composed of good lodgings is in charge of a special committee, and a special committee of men interested in each of the different specialties, as well as in the broad domain of medicine and surgery, is appointed to collect information regarding various public and private courses of instruction in medicine, surgery and the specialties.

*See column of Items in this week's issue.

The advantages of this Society are so obvious that every American who proposes to study medicine in Berlin should make application to its president, Dr. W. D. Miller, and within twenty-four hours he will receive accurate and precise information regarding all the private and public courses that are given, and can arrange special courses among the members; he will be able to secure a special discount on all books and instruments which he may purchase, and at the same time he will be able to obtain a list of lodgings and restaurants where he may go and feel perfectly comfortable. This information, which he acquires so quickly, would take, in the ordinary course of events, not less than two or three weeks, and with a strong probability that he would waste much more time; not to mention the advantage of meeting and knowing all of his countrymen that are in Berlin at the same time.

CLOTHES AND DISEASE.

The State of Massachusetts in 1891 passed an Act to prevent the manufacture and sale of unhealthy clothing, which during the last year has been made more stringent. It begins by defining as a workshop any house, room, or dwelling-place which is also used for the purpose of making, altering, repairing, or finishing for sale any wearing apparel of any kind. It requires these places to be licensed and puts them under the supervision of police inspectors, who are to report to the State Board of Health any evidence of infectious disease in goods or workshops, and empowers the Board to issue such orders as the safety of the public may demand. All articles made in tenements must bear upon them a label with the words "tenement-made," and showing the town where the work was done. The conditions of license are that the apartments and surroundings shall be absolutely clean, and that no work is to be done in a sleeping-room. Notice is to be sent to the inspector of the district if a case of infectious disease occurs in the family or if the family removes, and no person not being a member of the family is to be employed in finishing the articles.—*Ex.*

A CASE OF ISCHIO-PUBIOTOMY: FARABEUF'S OPERATION.

At the session of the Paris Academy of Medicine January 10, Professor Pinard show a woman with an obliquely contracted pelvis associated with synostosis or ankylosis of the right sacro-iliac synchondrosis, on whom he was led to perform a new operation, viz., ischio-pubiotomy.

She had previously had five children, all of whom had been extracted by artificial means. As a result four of the children were still-born and the fifth, who was born partially asphyxiated, only lived for five months. This, therefore, was her sixth pregnancy. She came to the Baudelocque Hospital for her confinement, "begging for a live child at any cost."

To attain this object without exposing the mother's life, Professor Pinard decided to perform the operation of ischio-pubiotomy on the lines indicated by Professor Farabeuf.

The operation was performed a few hours after the appearance of the first pains. It consisted in sawing through the horizontal and descending rami of the pubes, at a distance of two inches from the symphysis on the ankylosed side. Tarnier's forceps were then applied to the head at the inlet and a living child, weighing about eight pounds, was extracted without the slighest difficulty.

The operation itself presented comparatively little difficulty. The most troublesome part consisted in passing the chain-saw round the horizontal ramus of the pubes.

Immediately after the operation the pelvic diameter was increased by one inch and this must have been brought to about two inches by the passage of the head.

It was found unnecessary to wire the bones together, for they had fallen back into their natural position and the divided ends were in contact with one another. The wound was closed and the woman laid on the special bed for symphysiotomy cases.

The results of the operation were very satisfactory. The wound in the soft parts healed by first intention and the patient is now able to walk as well as she did before. She nurses her child, who now weighs about eleven pounds.—*Medical Week.*

THE KEELEY SYSTEM.

As we are located near Dwight, many patients from this city have been there, and from various conversations with them, and after hearing a description of their symptoms while taking the treatment, I have come to the conclusion that the following, obtained from one of the graduates who had the medicine analyzed, is the secret of the Keeley cure.

Patients on entering the institute are given a mixture containing

℞.—Aurii et sodii chloridi. . .	ʒss.
Strychniæ nitrat.	gr. iv.
Atropinæ sulphat.	gr. j.
Glycerini	ʒ ij.
Ex. fl. cinchonæ q. s. . . .	ʒxvj—M.

Sig.—One teaspoonful in water three times a day.

The members report four times a day and receive a hypodermatic injection of strychnine nitrate gr. $\frac{1}{30}$. They are told that they can have all the liquor they want. "If you feel like taking a drink," says the doctor, "just ask for it." Mark you now, here is the secret. If the patient asks for a drink of whiskey he gets it; but instead of the injection of strychnine nitrate, he receives one of apomorphine, gr. $\frac{1}{10}$. Of course, the whiskey makes him sick; he is unable to retain his once favorite beverage, and he promptly informs his fellow undergraduates, and write his friends glowing accounts of the great change and new life that have come over him since taking this wonderful cure, which he feels sure could only have been brought about, as Mr. Keeley himself said in a lecture here recently, by divine appointment.—J. J. Brownson, M. D., in *Medical News.*

CRIMINAL RESPONSIBILITY AND INEBRIETY.

The fourth and concluding lecture on inebriety was delivered on the 31st ult., in the rooms of the Medical Society of London, by Dr. Norman Kerr, on the Relation of Inebriety to Criminal Responsibility. He said that the Roman law made an allowance for intoxication, but the Grecian law did not. In Mitylene there was a double punishment for offences committed while the offender was drunk. The New York Penal Code laid down that drunkenness might be considered as to criminal intent. In German, Austrian, Swiss, Italian and Dutch law there was a distinction drawn between culpable and inculpable intoxication. English law exacted complete responsibility. In Austria a peasant farmer while intoxicated killed his brother. In Great Britain he would have been hung, or at least have received a long term of imprisonment. Under the Austrian code's provision of a reduction of punishment in the non-intent of intoxication he received nine months' imprisonment. He became a changed man and then headed a temperance reformation in his district, where a monument had been erected in honor of the services he rendered to his country. Some authorities, including Coke, held that drunkenness aggravated the offence; others, such as Hale, that the punishment should be equal. Bnt there had been for some time

gradual development in the recognition of, in certain cases, a diseased brain condition short of lunacy, which carried with it irresponsibility. Cases were cited where the verdict was based upon such a diseased inebriate cerebral state. Sir Henry James's *résumé* of existing law marked a long step in advance, but was pronounced by Dr. Kerr to be defective. In several trials a plea of delirium tremens had resulted in a verdict of acquittal. Diseased inebriate offenders should be treated for their disease and many of them would be cured. Probably the first curative effort would be initiated among the class of inebriate police-court offenders by some fairly practical reformatory method, combining medical with other ameliorative treatment.—*Lancet.*

THE INTERNATIONAL CONGRESS OF CHARITIES, CORRECTION AND PHILANTHROPY.

This Congress, associated with the Chicago Columbian Exposition, has issued its circular, from which we quote the following paragraphs:

The Congress will meet in the city of Chicago on Monday morning, June 12, 1893, at 10 o'clock, in a hall to be hereafter announced.

The object of the International Congress of Charities, Correction and Philanthropy is to bring together in the city of Chicago during the time of the World's Columbian Exposition interested persons of all countries to discuss matters charitable, correctional and philanthropic.

The governments of foreign nations, of the United States of America, and of the individual States of the United States; scientific societies, official bodies, and corporations and societies which own or control charitable or penal institutions, or are engaged in any kind of philanthropic work, are invited to co-operate with the committee of organization and to send representatives to the congress. Membership in the congress will be limited to persons bearing credentials from the authorities and organizations herein referred to, and to such private individuals as are interested in charitable and penal work as may be admitted to membership by vote of the executive committee or who may be specially invited by the committee of organization, or the chairman and secretary of a section.

Delegates must present their credentials before registering as members of the congress.

From the obvious necessities of the case, no persons other than those herein specified can be permitted to participate in the debates or to vote on questions before the congress. But a general invitation is extended to all persons who may be interested in the questions discussed to attend the sessions and listen to the debates.

Among its seven sections two are given to essentially medical subjects; these are: Section 3. Hospital Care of the Sick, the Training of Nurses, Dispensary Work, and First Aid to the Injured. Chairman, Dr. John S. Billings, Surgeon U. S. A., Washington, D. C.; Secretary, Dr. Henry M. Hurd, of Maryland, Superintendent Johns Hopkins Hospital, Baltimore. Sub-section, On the Training of Nurses. Chairman, Miss Isabel A. Hampton, Superintendent Training School for Nurses, Johns Hopkins Hospital, Baltimore. Section 4. The Commitment, Detention, Care and Treatment of the Insane. Chairman, Dr. G. Alder Blumer, of New York, Superintendent State Hospital for the Insane, Utica. Secretary, Dr. A. B. Richardson, of Ohio, Superintendent Asylum for the Insane, Columbus.

LEAD POISONING IN WOMEN.

In commenting editorially upon the recent death of a woman from acute lead poisoning, the *British Medical Journal,* January 7th, says:

All medical men are more or less acquainted with the far-reaching consequences of lead when introduced into the system; but most of us who are living away from these industrial centres can hardly realize the suddenness with which the system is invaded, or the extent to which its victims are claimed by death or left as helpless wrecks, blind, epileptic, or paralysed; frequently, too, at so early an age that they have hardly known what work really means.

In Dr. Oliver's Goulstonian Lectures delivered at the Royal College of Physicians in 1891 (which we were able to report in full) are given numerous instances of that extremely dangerous form of plumbism known as lead encephalopathy. In this the patient generally dies; or, if recovery occurs, it is attended with blindness. One of the principal points brought out was that women—young women especially, say from 17 to 25 years of age—are peculiarly prone to this particular form of lead poisoning. In some way, at present not understood, the menstrual function becomes deranged, there being metrorrhagia, or amenorrhœa, and closely following upon this comes plumbism in some form or other.

There is a feminine proclivity to plumbism, a fact insisted upon by Dr. Corner, of the East of London, as well as by Dr. Oliver, of Newcastle, both of whom have had unusual opportunities of studying the disease. If this is so, why allow women to work in the lead factories at all? It can only be for financial reasons that they are employed, female labor being cheaper than male. It is perfectly true that the employers of labor as a rule do all they possibly can in the factories to obviate the risks consequent upon the manufacture of white lead. Baths are provided and superintended by female attendants who are told off to look after the women; masks and overalls are worn, and in the yard there is always at hand a plentiful supply of acidulated drinks. All the details insisted upon by the Act of Parliament are scrupulously attended to, but it is perfectly evident that the warm bath cannot be utilized by women with the frequency necessary to exercise a protective influence. Metrorrhagia, for example, is an obstacle to its employment. As for the masks, women will not wear them owing to the difficulty of breathing they cause, and, as for the overalls, they really offer very little protection.

HYSTERICAL DEAFNESS; INABILITY TO SPEAK.

Describing in the *Lancet*, February 4th, some "Strange Incidents in Practice," Dr. Dally, of London, says:

Once and once only, have I seen a case of pure hysterical deafness, and from its very completeness it is worth recording—that of a young lady who was brought to me by her mother and medical attendant, the latter an exceedingly able man and thoroughly appreciating the situation. One morning on awakening she professed to be unable to hear any sound whatever, and conducted herself so appropriately to this condition that it was found imposible to surprise her into any indication of hearing. A year previously she had professed to be absolutely blind and was examined by a well-known ophthalmic surgeon, who declared that both eyes were perfectly healthy. Notwithstanding this, she proceeded to move about and behave in every minute detail as if totally blind, and continued in this course for many weeks, until one day she said her sight had suddenly returned. When I saw her I was certain that she could hear, and proposed (not in her hearing of course) that she should be led across a room and a gun should be unexpectedly fired at some distance behind her. I imagined that she could not fail to manifest some signs of hearing the explosion, and that possibly after that she would declare the hearing to have returned. This experiment, or rather treatment (for so I regarded it), was not permitted, and she remained for over six

months without alteration, when one day the hearing was, she affirmed, as suddenly restored as the previous blindness. It is certainly not conceivable that in any other class of life than that to which she belonged this attempt to excite sympathy (for this appears to me the nearest to a true explanation that I can fancy) could have been so prolonged as it was—for there are numerous ways in which the deception could have been exposed—if those about this girl had appreciated the position and had shown some determination in the matter.

INABILITY TO SPEAK.

A more curious circumstance than this in relation, not to hearing, but to speech, once came under my notice. A physician was occasionally for several years consulted by a gentleman with regard to his health, which was, however, generally good. The patient was a middle-aged man of robust appearance. His hearing was perfect, he could understand everything that was said to him; but he never spoke. The consultations were conducted on his part in writing and he habitually carried about pencil and paper—in fact, writing was his only means of communication. He was an intelligent and fairly educated man. My friend the physician knew that I was very much interested in the acquirement of speech in the loss of speech following loss of hearing in children, and in its recovery after the return of hearing, so he asked his patient to call upon me. The interview was conducted as usual, the patient writing and I speaking in the ordinary voice. I found the ears healthy and the hearing normal. I could not get a satisfactory explanation of how he lost the power of speech, except that it occurred in boyhood. About a year after my interview with him he went again to see the physician, and, to the latter's astonishment, spoke like an ordinary person, saying that the power of speech had suddenly returned, adding that he was utterly unable to ascribe this return to any cause, any more than he was able to explain the sudden loss of speech—a simple inability to enunciate words to begin with, and next, a sudden return of this power.

This was an entirely new experience to me in the loss and recovery of speech. I had frequently watched the gradual loss of speech when the hearing had been lost in young children from scarlet fever and other causes, until the child had in few months become quite dumb. I had also frequently watched the acquirement of speech in a child who had lost it from partial deafness in infancy and regained it after the hearing had been recovered under treatment, and I had, of course, often enough observed the acquirement of speech in a deaf and dumb child under instruction in lip reading and in articulation. But this was to me, and still remains, something so entirely exceptional that I am quite at a loss to offer any explanation.

DISPENSARY FOR PLASTER JACKETS.

We have just received the report of the Dispensary for Plaster of Paris Jackets and Free School for Deformed Children. This excellent charity is conducted by Miss C. C. Barnwell at 407 W. Hoffman Street, in this city. The methods followed by Miss Barnwell were fully described by her in an interesting paper, published in this JOURNAL, March 19th, 1892, and now supplied by her in pamphlet form for 25 cents. No regular charge is made, as the patients are generally sought from among those who cannot or will not seek the private physician or the hospital.

Each case is examined by a physician before the jacket is applied.

The report for 1892 is as follows: Contributed by friends, $547.60; contributed by patients, $179.25; sale of materials, $11.36; balance from 1891, $34.80;

total, $773.01. Expenditures for 1892, $721.64; balance, $51.37; total, $773.01. Visits paid and received by Dispensary and School, 2,600; cases continued from 1891, 38; new cases taken up, 28; cases inquired into, 9; plaster jackets made, 407; plaster bandages prepared (yards), 9,348.

This was the first year spent in our new abode, and owing chiefly to the pleasant surroundings the Dispensary and Schools have increased in efficiency and numbers.

In the Dispensary special attention has been given to removable plaster of Paris corsets for ladies with spine disease, or requiring simply a strong and comfortable support.

A lady (with salary) takes part in all the work excepting the application of jackets. It became necessary this year to employ a lady (with salary) to open the schools in October. She is kindly assisted by The King's Daughters, and others, giving us one morning each week.

The roll calls for 6 white scholars and 15 colored scholars, in separate rooms. Their attendance is irregular, and they vary so much in ability that they cannot be put in classes. Teachers and scholars have attended school 652 times in the year.

Two white boys have done well at books, and instead of "going on wheels" as formerly, they now walk about on crutches, specially provided by friends of the school.

Several colored children have been so far cured and brought forward in books that they now attend the public school. Those most afflicted like our school best, learning in books, with lessons in sewing, singing and religious instruction. The physical exercises given daily have been of marked benefit and pleasure.

Medical Items.

Paper Weights—Delinquent Subscribers.—*"Truth."*

The highest German court has decided that legal human life begins with the commencement of labor; its destruction anterior to this is not murder. This may be good law, but it is bad physiology. Physiology should determine the law rather than law the physiology.—*American Lancet.*

The French Minister of Public Instruction has, it is stated, submitted to the Council of the Faculties of the Universities of France a proposal for the establishment of a medical degree superior to the ordinary M.D., carrying with it the style and title of "Docteur des Sciences Medicales" (Doctor of Medical Science).

The Government of Venezuela and the Pan-American Medical Congress.—Senor P. Ezequiel Rojas, the Venezuelian Minister of Foreign Affairs, has forwarded on behalf of his government through the U. S. Charge d' Affaires at Caracas, a formal acceptance of the invitation issued pursuant to the joint resolution of the United States Congress to the various governments of the Western Hemisphere to send official delegates to the Pan-American Medical Congress. The selection of delegates has not yet been made but the names will be forwarded at the earliest possible moment.

A very favorable review of Dr. Wm. B. Canfield's recently published book, on "Hygiene of the Sick-Room" appears in the *Baltimore American,* Feb. 14th.

The *American* says in closing: "Dr. Canfield has covered the ground in a creditable manner, and the book is commended to all, whether nurses or not. The literary part of the work is admirably done. The book has been recommended by the health commissioner of Baltimore, and he has had a copy given to each sanitary inspector." The work is for sale by Cushing & Co., of this city.

The food of old age should be simple, nutritious but not too concentrated, not too largely nitrogenous. It should be taken four times a day, in less quantity as a whole than in middle life, and in a soft and friable condition. Stimulants and narcotics should be avoided, unless required by lifelong habit. Tea and coffee may be allowed in moderation. The calls of nature should be promptly attended to. All excesses should be avoided, and regularity, temperance and moderation observed in all things. Careful protection from cold and atmospheric vicissitudes is required. Avoid worry and fret. Look on the bright side of life. Take plenty of sleep. Have the best of care in health, and of nursing in sickness. Avoid all passion, excitement, luxury, over-exertion. Thus will life be lengthened, and old age made enjoyable.—*Journal American Medical Association.*

Dr. Henry J. Berkley, of this city, has written to the Mayor upon the care of the insane at Bayview Asylum. Dr. Berkley has been visiting physician at the asylum from the Johns Hopkins Hospital three years. In discussing the proposed appropriation by the City Council of $65,000 for the erection of a building which will accommodate about two hundred insane persons, Dr. Berkley calls attention to the increase of insane patients at Bayview from 148 in 1885 to 394 in 1892, an average increase of 36 annually. He states that the proposed building will not be large enough for the needs of the future, and maintains that the conditions surrounding insane patients at Bayview are unfavorable to recovery. Dr. Berkley suggests that it would be more economical for the city to use all the buildings at Bayview for paupers and seek a separate locality on which to build quarters for the insane. He recommends inexpensive buildings on the cottage plan, each accommodating from thirty to fifty inmates, with sufficient land to provide suitable employment for able-bodied patients.—*Sun.*

The Section on Laryngology and Rhinology of the Pan-American Medical Congress is now thoroughly organized with secretaries in all the countries of South America as well as in the United States and Canada. The President, Dr. E. Fletcher Ingals, 36 Washington St., Chicago, is making a thorough canvass to secure a large number of good papers for the Section, and aided as he will be by the able Secretaries, Drs. Murray and y Alonso, and the corps of honorary Presidents, he feels assured of the success of this department of the Congress.

The honorary Presidents are: Dr. Harrison Allen, Philadelphia; Dr. Franke H. Bosworth, New York; Dr. J. Solis-Cohen, Philadelphia; Dr. D. Bryson Delavan, New York; Dr. J. F. Dixon, Portland, Oregon; Dr. Stephen Dodge, Halifax; Nova Scotia; Dr. W. C. Glascow, St. Louis; Dr. Frederick I. Knight, Boston; Dr. George M. Lefferts, New York; Dr. Alvaro Ledan, Villa Clara, Cuba; Dr. John N. Mackenzie, Baltimore; Dr. David Matto, Lima, Perú; Dr. P. Emelio Petit, Santiago, Chile; Dr. John O. Roe, Rochester, N. Y.; Dr. Federico Semeleder, City of Mexico, Mexico; Dr. Charles E. Sajous, Paris, France.

The Secretaries for Foreign Countries are: Dr. Ovejero (Piedad 22), Buenos

Ayres, Argentine Republic; Dr. H. Guedes de Mello, Rio de Janeiro, U. S. of Brazil; Dr. G. W. Major, Montreal, Canada; Dr. Felix Campuzano (Virtudes 33), Havana, Cuba; Dr. Luis Fonnegra (Calle 10, Numero 263), Bogota, Republic of Columbia; Dr. Fabricio Uribe, Guatemala City, Guatemala; Dr. Henri Goulden McGrew, Honolulu, Hawaii; Dr. Angel Gavino (Cocheros 15), City of Mexico, Mexico; Dr. J. Midence, Leon, Nicaragua; Dr. Eugenios Cassanello, (San Jose 119), Montevideo, Uruguay; Dr. Napoleon F. Cordero, Merida, Venezuela.

All physicians interested in this Section are requested to correspond with the secretaries for the United States, Dr. J. Maron y Alonso, (Spanish speaking), LasVegas, N. M., Dr. T. Morris Murray (English speaking), Washington, D. C.

The London Post-Graduate Course was founded in January, 1890, in order to increase the opportunities for clinical instruction in London, for qualified members of the profession; and also with a view to extend the usefulness, for teaching purposes, of those hospitals to which there is no medical school attached.

During the spring term (January to March, 1893), instruction will be given by members of the medical staffs of the following hospitals:—

The Hospital for Consumption and Disease of the Chest, Brompton.

The Hospital for Sick Children, Great Ormond St., Bloomsbury.

The National Hospital for the Paralysed and the Epileptic (Albany Memorial), Queen Square, Bloomsbury.

The Royal London Ophthalmic Hospital, Moorefields.

The Hospital for Diseases of the Skin, Blackfriars.

Bethlem Royal Hospital for Lunatics.

The London Throat Hospital, Great Portland St.

Also at the Bacteriological Museum, King's College; and at the Parker Museum.

Also a course on morbid anatomy and lectures on midwifery and diseases of women, at 101 Great Russell St., Bloomsbury, and a course on medicine and surgery at the Central London Sick Asylum, Cleveland St., W.

The fee for any single course will be from $5 to $10, according to the number of lectures or demonstrations.

The fee for the whole course will be $80.

The practice of the respective hospitals is open to gentlemen attending the post-graduate course on the following terms:

Hospital for Consumption, Brompton, for one month, $5; for six months, $26; perpetually, $55.

Hospital for Sick Children, Great Ormond St., for one month, $5; for three months, $16; for twelve months, $26.

Royal London Ophthalmic Hospital, Moorefields, for one month, $5; for six months, $16; perpetually, $26.

London Throat Hospital, Great Portland St., for one month, $5; for three months, $11; perpetually, $26.

The conditions of attendance at other hospitals may be learned on application.

Fees may be sent to the Secretary, J. Fletcher Little, M.B.,60 Welbeck Street, Cavendish Square, London, W.

The lectures are so arranged that one or two are given a week at each hospital and that the hours do not conflict.

There is also a summer term in May and June, and a winter term in October and November.

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REPORT OF TWO CASES OF OBSTETRICS.*

BY WILMER BRINTON, M. D.,
Professor of Obstetrics, Baltimore Medical College.

Mr. President and Gentlemen:—In June, 1888, I delivered a woman with puerperal eclampsia of a living child; the woman dying twelve hours after delivery. Since that time, I have delivered over three hundred women, presenting the usual number of complications, and among the operative measures performed have been craniotomy, versions, high and low forceps, but without mortality to the mother until the unfortunate case which I put on record to-night.

CASE I. *A Puerperal Woman Dying On Her Seventh Day of Scarlet Fever.*—On Sunday, March 6th, 1892, upon returning to my office at 3 o'clock P. M., I found awaiting me two calls, one from Mrs. D., one from Mrs. H., both cases of obstetrics, which I had been engaged to attend, and had been expecting for several days. Mrs. H., a primipara, living nearest to my office, I saw first. Upon making the usual vaginal examination, I found her in the first stage of labor, vertex presentation, position O. L. A. As the stage and progress of labor did not call me to remain with her, I visited Mrs. D., who lived quite a distance from my first patient, Mrs. H. I found Mrs. D., who was in labor with

*Read at the regular monthly meeting of the Gynæcological and Obstetrical Society of Baltimore, January 10th, 1893.

her second child, well advanced in the first stage. As in the case of Mrs. H., I found the child presenting vertex position (O. L. A.) As the cervix was not fully dilated and the bag of water unruptured, I ventured to leave my patient for the purpose of dining, but was somewhat chagrined, upon returning at 4.45 P. M., to find that the child had been born just three minutes before my arrival. I cut the cord, expressed the placenta, made my patient dry and comfortable. I saw that the uterus was well contracted, and as she was doing well generally, without waiting to see the baby washed and dressed, I drove rapidly back to Mrs. H., whom I found well advanced in the second stage of labor. I delivered her of the child at 7 P. M.

On Monday, March 7th, I visited Mrs. D., and found her doing well; while conversing with her she incidentally said her little son, two and one-half years old, had been quite feverish throughout the night, but at this time he was playing about the lying-in room. As I was not requested to interview or prescribe for him, I did not do so. On the next day, Tuesday, owing to some detention, I did not see my patient until late in the afternoon, about forty-eight hours from the time of her confinement. I found her quite sick, temperature 102°. Pulse 110-120, and complaining of a very sick stomach; indeed, she had been vomiting more or less during the entire day. I was also asked to see her little son, who had had fever all night and during the day. He was also vomiting constantly. I found upon a thorough examination that he had all of the characteristic symptoms of scarlet fever—temperature 102½°, pulse 130, pharyngitis, "strawberry tongue," etc.—but at this time, four o'clock in the afternoon, no eruption; still I gave an opinion that it was a case of scarlet fever and ordered him to be transferred to another room and to have as much isolation as possible. An examination of my puerperal patient now made with the facts in the boy's case before me, led me to suspect I had to do with a case of scarlet fever in the lying-in woman, especially so as an examination of the breast, uterus, etc., gave me a negative result for the causation of fever. I washed out the vagina and ordered quinine in decided doses. On visiting my patients at eight o'clock next morning, I found the boy covered from head to feet with the eruption of scarlet fever, and my puerperal patient quite sick, fever higher, vomiting some, one of the most decided "strawberry" tongues I have ever seen, pulse rapid, no milk in breasts, lochia diminished. My evening visit found the characteristic scarlet fever rash appearing on the breast and abdomen of Mrs. D., and one of the most annoying symptoms complained of to me on this visit by Mrs. D. was the intolerable desire to scratch, the itching being unbearable. The next day, Thursday, found my patient thoroughly covered with the scarlet rash, temperature 104°, pulse 125. Evening temperature 105°, pulse 135. Had severe pharyngitis; vomiting had ceased; complained of severe headache. A midnight visit found my patient with a temperature of 106°, pulse 140, more or less delirious. Antipyretics, including sponging the face and upper extremities with cold water, caused some reduction of temperature, which made the patient more comfortable, and she had less de-

lirium the balance of the night. The next day, Friday, I found my patient decidedly worse, pulse rapid and weak, temperature high, delirium marked; towards evening the symptoms grew more alarming; between midnight and morning she became comatose, in which condition she remained until she died some few minutes past midnight, on Saturday, March 12, 1892, six days and seven hours after the birth of the child. My treatment during her illness was iron and quinine in large doses, antipyretics, stimulants, concentrated food, with gargles for the throat, and application of glycerine and cold cream to the skin to relieve the intolerable itching. The little son grew better of the scarlet fever under similar treatment, the temperature subsided, desquamation began, and the indications were favorable for a speedy recovery. Then followed a high temperature and rapid pulse, and within a few hours the pharynx and nasal passages were covered with a thick diphtheritic membrane. Under local and constitutional treatment this membrane finally sloughed off and again my little patient seemed to be on the road towards rapid recovery, when we had sequelæ to appear in the shape of an adenitis of the cervical glands, which finally suppurated. Opening them and giving exit to a large amount of bad-smelling pus seemed to give marked relief to the boy, but later in the same day he died suddenly, and while I was not present at the time of his death, I would judge from the description given by those who were present that he died from cardiac paralysis. On the morning of the day on which my puerperal patient died a young sister came from the country to assist in taking care of her sick sister and nephew. I saw her within a few hours after her arrival and ascertaining that she had never had scarlet fever, I informed her of her danger, but in spite of all my efforts and orders she took partial charge of her dying sister. One week from the day she entered the house she was stricken down with a severe attack of scarlet fever, which was followed by a severe attack of desquamative nephritis, within two weeks. She had suppression of urine for over a day, marked œdema over her whole body, large quantities of albumen in urine, and for several days was in great danger, and six weeks later, when I dismissed her, owing to my absence from the city for several months, she was still extremely weak and debilitated, showing how grave her illness had been. My object in reporting to this Society this extremely distressing case to all parties concerned is to get an expression of opinion upon the incubation period of scarlet fever.

If I attended Mrs. D. at 5 P. M. on Sunday and her 2½ year old son had the prodromic stage of scarlet fever within twenty-four hours from this time, and my puerperal patient within forty-eight hours, did I infect them? If so, how did Mrs. H., escape, whom I saw before I visited Mrs. D., and whom I delivered of her child in about two hours after the birth of Mrs. D's. child? In an incidental conversation I had with Professor Welch upon the subject, his views were that it was impossible for me to have done so. The period of incubation for the young woman who came to nurse her sister was just one week from the time of her first exposure. Judging from the authorities at my command, and from

my own personal experience, the period of incubation is generally within six days, but quite a number of cases have been reported in which the period seems to be numbered by hours instead of days. In the transactions of the Clinical Society of London, Volume IX, 1878 (quoted by Smith, of New York, in his book on Diseases of Children), the late Charles Munchison gives statistics of seventy-five cases of scarlet fever, showing the incubative period to vary from twenty-four hours to six days; the greater number of these cases reported the fever developed within three days from the time of exposure. Whatever the incubative period may be it brings up the interesting question, Shall the general practitioner who meets daily in his practice cases of scarlet fever, give up his obstetrical work, or shall he, after taking proper precautions, which will include change of clothing, bath, rigid antiseptic precaution, do the obstetrical work which comes under his care?

Case II. *A Case of Labor, the Woman Having Organic Heart Disease.*—Mrs. B., age 27 years, of a neurotic family. Having always had for years past an occasional epileptic convulsion, irregular in menstruation, and with a grave cardiac affection, the result of a severe attack of endocarditis following rheumatism in childhood. She married against the wishes of her surviving parent and family who knew her condition, became pregnant shortly after marriage, and I was requested to take charge of her confinement, which was expected some time about December 1st, 1892. The form of cardiac disease was lesion of the mitral valve; still for years the amount of hypertrophy existing completely compensated for the existing valvular disease, but during her pregnancy, and two or three times previous to that event, within two years, I had attended Mrs. B. for acute pulmonary œdema which threatened for a short time to close her earthly career. With this history the approaching confinement was looked forward to by her family and myself with some apprehension. I was first summoned to see her Friday night, November 25, 1892; found her having some pain, but a vaginal examination found her not to be in true labor; this examination with auscultation and palpation confirmed previous examinations that the child was presenting vertex with the occiput to the mother's front and head low down and well fixed in the pelvis. Small doses of opium were ordered, and the false labor pains soon ceased, the patient having a good night. On the following day, Saturday, I saw Mrs. B. twice, and on my evening visit decided that true labor was beginning. I visited her at nine o'clock at night and found labor progressing, but as my patient was complaining of symptoms which always before indicated the approach of an epileptic convulsion, kali-bromidi, grains xx, was given every hour until she had taken nearly two drachms. The pains continued good, progress was made, the patient cheerful and courageous, pulse kept up to the usual standard until between three and four o'clock Sunday morning, when within a short time we had a very marked change in the patient's condition. The pulse became rapid and weak, the pains ineffectual, the soft parts were hot and dry, the patient fretful and discouraged; the head low down in the pelvis gave no indication

of rotating. Soon pulmonary congestion and œdema set in, the patient began to spit blood and the mucous rales in her chest could be heard some distance from her bed; pulse 140; some difficulty in breathing; and as no improvement took place, I sent for my associate, Dr. J. F. Crouch, who agreed with me on the necessity of delivering the patient at once. The patient being prepared for forceps delivery, chloroform was given, and when well under its influence, I applied Simpson's forceps. The head low down, but not rotated, was only brought down on the perineum after considerable traction; the forceps were then removed, and within a few minutes by the feeble contractions of the uterus, plus pressure from above made by my hands on the uterus, the child was delivered profoundly asphyxiated, but thanks to the energetic and intelligent efforts of Dr. Crouch, we had the pleasure, after a long while, of hearing it cry lustily. The third stage of labor was completed within a few minutes by Credé's method. The patient did well, and as her lying-in period was uneventful, I need not detain this Society by any relation of it. Both my associate and myself watched the effect of the chloroform upon the patient's heart during its administration and we were both impressed with its favorable action. Just as soon as the patient was under the influence of the chloroform, before forceps were applied, the pulse became more regular and stronger, her general condition was also decidedly better, and although it was necessary to make very decided traction to deliver, we both believed our patient to be in a better condition than she was before we began our obstetrical operation procedure.

Lusk says: "Mitral lesions are of more grave significance than those at the aortic orifice, and mitral stenosis is particularly dangerous because of its tendency to produce dilatation of the left auricle and the heart." In the same article, he says: "Women with cardiac diseases of any considerable gravity should be dissuaded from marriage, and the indications for medicinal treatment are the same as for cardiac diseases uncomplicated by pregnancy." Chloroform, Lusk believes, should be administered with special caution during parturition when the patient has cardiac disease; "McDonald, however, believes that, cautiously administered in the second stage, chloroform is useful by diminishing the bearing down efforts, and in order to lessen the latter, the same author urges as of extreme importance the timely application of the forceps, or the performance of version in suitable cases, when the second stage of labor be in any way prolonged." Parvin, Playfair, Barnes, Schroder and other authorities at my command practically agree with this statement. Winckel says: "Cardiac diseases do not contra-indicate the use of anæsthetics during labor, but they are useful by diminishing any injurious effects from straining, besides quieting the action of the heart and keeping it regular.

Dr. Robin, of Paris, has written the New York *Herald* that the epidemic in Marseilles, about the exact nature of which there has been considerable doubt, is in his opinion genuine cholera, but that there is no immediate danger of a spread of the disease from this point as an infecting centre.—*Medical News.*

THE PRESERVATION OF THE INTEGRITY OF THE DIGESTIVE APPARATUS.

BY EDWARD ANDERSON, M. D., ROCKVILLE, MD.

So many prominent persons have died recently, and heart failure assigned as the cause of death, that the newspapers are constantly asking the question, "What is heart failure?" Generally, I think, the proper answer would be "Indigestion."

The upper classes in this country eat too much and exercise too little, and especially is this the case as they advance in life, when the heart becomes weakened and danger from heart failure is greatest. In sudden cases of heart failure, stimulants often fail to do good. Calomel and soda are usually beneficial, but relief is rarely obtained until vomiting occurs. Last fall, I was treating an elderly lady, who had organic disease of the heart, for malaria. Her life might have been prolonged for years, had she controlled her appetite, but that I could not prevail upon her to do. She ate everything she wanted, and always wanted what she ought not to have.

One night a messenger came and told me she was dying. When I reached her bedside, I found her unconscious and with a pulse scarcely perceptible. Her nephew was with her and said how sorry he was to have her die without signing a certain paper, as it would save a great deal of trouble and expense—speaking of her, as every one else did, as already dead. Had she been left alone, I am sure she would have died of what is called heart failure in less than an hour. I ordered an enema, and left a strong solution of soda to be gotten down her throat as best they could, during the night. This old lady recovered sufficiently to transact the legal business the next day, and lived two days after.

Last December, a man who lives a mile out in the country came in great haste for me to see his ten months old child which, he said, had fainted, and he knew would be dead before we reached his house. I asked him if the child had been eating pork, and he answered that it had—also gravy. He thought the child had been poisoned, but I was sure the weakness had proceeded from nausea, and that it would reject the offending matter, which it did, and, by the time we arrived, had recovered.

Nothing, except hæmorrhage, weakens so rapidly as nausea. Unless they go into convulsions, children always recover by throwing off the offending material, but elderly persons, and those suffering from organic disease of the heart, are often not so fortunate. If persons would eat less and exercise more, I think we would hear very little of heart failure.

The estimated cost of the new St. Luke's Hospital, NewYork, the plans of which have been perfected, is $3,000,000. The valuation of the present site and buildings at Fifth Avenue and 54 Street has been fixed at $2,500,000; but the property will not be surrendered until the completion of the new hospital, which it is expected will be in the summer of 1894.—*Boston Med. and Surg. Jour.*

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JANUARY 20, 1893.

The 275th regular meeting was called to order by the President, Dr. Wm. E. Moseley.

Dr. Harry Friedenwald exhibited a case of exophthalmos due to idiopathic hæmorrhage into the orbit. One morning the patient, a robust negro man, arose feeling quite well. After washing, he felt a sudden pain in his eye and found the eye protruding and sensitive. The eye-ball was not at all injected and the only reason for the exophthalmos that could be assigned was an orbital hæmorrhage. The movements of the eye-ball were very much restricted. During the next two days the pain was greatly diminished and the movements were increased. The vision of the affected eye has been greatly impaired since the hæmorrhage. No blood has yet appeared under the conjunctiva. There are a very great number of cases reported of traumatic orbital hæmorrhage with the same symptoms, but there are only a few cases of idiopathic hæmorrhage on record. The patient's history throws no light upon the cause of the hæmorrhage.

Dr. A. Friedenwald remembered a similar case which he had seen in a colored man some years ago. The protrusion of the eye-ball came on very suddenly and could be ascribed to no other cause than orbital hæmorrhage. These hæmorrhages are by no means innocent, for the pressure which they exert upon the nerve of the eye is very prejudicial and explains the rapid decrease in the patient's sight. In traumatic cases accumulation of blood in the orbit is usually followed by total atrophy of the optic nerve.

Dr. S. T. Earle exhibited a Langdon rectal tube. This tube was introduced by Dr. Langdon, of the Miami Medical College of Cincinnati, Ohio. It presents many advantages over the tube ordinarily in use. It is five feet in length, being intended to reach from the anus to the cæcum. It is found extremely valuable in rectal alimentations, as the enema may be carried up all the way into the large bowel and is not followed by a desire for speedy evacuation, as is the case where the nourishment is injected only into the rectum. The enema by this means comes into contact with a larger absorbing surface. Another advantage of this tube is its resistance. It is a $\frac{1}{2}$ inch tube with only a $\frac{1}{8}$ inch opening. This prevents the kinking and bending upon itself which is so likely to take place in the ordinary rectal tube. The opening is at the end and not upon the side. This allows of an easy introduction, as by letting the enemata flow in gradually the bowel is distended in advance of the tube. In cases of fecal impaction this resistance and direct opening are of very decided advantage. This tube can be made to pass the fecal obstructions and throw the enema above the obstruction. It is also valuable in the treatment of oxyuris vermicularis. It has been shown by Heller that the habitat of this worm is about the cæcum and not about the rectum, as has been supposed. By this tube our medicaments can be thrown where they will do the most good.

Dr. Robert W. Johnson reported A DOZEN ACCIDENT CASES TREATED BY THE BLOOD-CLOT METHOD: 3 gunshot wounds, 2 compound fractures of the skull, 2 compound fractures of patella, 1 compound fracture of tibia, 1 of compound dislocation of elbow, 1 punctured wound of the knee-joint, 1 plastic amputation of the breast, and 1 strangulated testicle. These cases were all

eminently successful. They did not represent all of the series of cases treated by this method but only the most successful ones. While the method is not universally successful, still it may be often trusted and when it fails it does not leave the patient in a much worse position than had it not been tried.

Dr. W. S. Halsted congratulated Dr. Johnson upon his cases and thought they were excellent illustrations of what could be done by the method.

There is a point that is not generally understood when the blood-clot method is spoken of. Schede, who advocated this method, made use of it to fill up dead spaces in bone to take the place of sponge, decalcified bone, cat-gut and other foreign materials, and he contradicted the views of Bergman, who thought it was absolutely fatal to good results to allow blood to remain in the wounds. He did not, however, ascribe any beneficial antiseptic effects to the blood-clot. He did not know at that time of the experiments of Nuttall, and of others since Nuttall, which showed that the blood of some animals has the power to destroy germs, such as the typhoid germs, when inoculated with these germs. No one has yet succeeded in killing pyogenic organisms with human blood.

Perhaps the value of the method lies in the fact that we are no longer afraid of blood in a wound and so we do not feel anxious to obliterate dead spaces which are difficult to obliterate and we do not have to prevent very minute arteries from bleeding. We have learned that blood is not very harmful in a wound, but we have not learned that it is a thing to be desired in a wound.

It is best to have a wound as dry as possible and to close it immediately, provided we can have it dry without constricting tissues with our ligatures and sutures. We have become sure that one of the most important things in technique is to avoid the strangulation of tissue. This is more important than the employment of antiseptics, more important than disinfecting the skin of the patient and perhaps disinfecting our own hands, but not more important than disinfecting the ligatures.

Dr. J. E. Michael said that similar cases to those related by Dr. Johnson had been treated successfully by other methods. There can be no object in having a blood-clot except where there is a dead space to deal with. Where wounds can be made clean and closely approximated without constricting tissue it seems reasonable to so treat them rather than to introduce an element that may be harmful.

Dr. J. W. Chambers: We have about come to this conclusion, that a blood-clot is probably less injurious to tissue than a drainage tube; that it does very little harm, whether it does good or not.

Dr. Randolph Winslow believed that wherever there are dead spaces, such as cavities in bone, which heal with difficulty by the process of granulation and cicatrization, the blood-clot affords a scaffolding by which the process of repair is very much facilitated. He feels safer in making use of drainage where there are considerable cavities which are liable to be filled with fluids which may decompose, but in small cavities or bone cavities it is frequently desirable to have them filled with blood.

Dr. A. Friedenwald: A blood-clot always forms after the enucleation of an eye. Before the period of antisepsis he always expected copious suppuration to follow enucleation and it never failed. With antisepsis he never has suppuration.

Dr. Johnson said that while the blood-clot will not destroy germs, and he had never intended to give the impression that it would, it will allow us to close up our wounds without too much interference. It is nature's method of filling up

dead spaces and is what occurs in sub-cutaneous wounds and simple fractures. It enables us to do away with the drainage tube to a great extent and this is an extremely valuable addition to surgery. It makes each operation simpler. In endeavoring to check the hæmorrhage of small oozing by sponge or gauze or other means we do injury to the tissues. We accomplish a good work by the avoidance of this injury.

STATED MEETING HELD FEBRUARY 3, 1893.

The 276th regular meeting was called to order by the President, Dr. Wm. E. Moseley.

Dr. G. J. Preston exhibited a patient suffering from a peculiar nervous affection of his left arm. The patient, a man 26 years old, has done hard work all his life. He has used his left hand rather more than his right. Last October he had a fall and struck on the shoulder of the affected side and the pathological condition developed soon after. The arm is very muscular and there is no evidence of paralysis, no loss of sensation and electric reflexes perfectly normal. The patient's hand assumes all sorts of queer positions, due to contracture of the muscles; and no sooner is one position reduced than another one immediately ensues, due to the contracture of a different group of muscles. These peculiar phenomena disappear entirely during sleep. Dr. Preston was inclined to believe that the condition was one of hysteria.

Dr. Walter B. Platt read a paper upon THE FACTOR OF AGE IN SURGICAL OPERATIONS. His conclusions were based upon operations done by himself upon children and aged people. He has never seen any ill effects in children from confinement to bed for weeks and months in hygienic surroundings. They stand confinement to bed and house better than any other age. In them ether anæsthesia is quickly induced and consciousness quickly regained. He has never seen any bad effects on the circulatory system during or after the administration of anæsthesia in children. The only case of shock which he had seen was in a case of osteo-myelitis of the femur where a great deal of suppuration had been going on for two or three years. A proportionate hæmorrhage is probably better borne by a child than by an adult. Children do not tolerate well an operation where the intestines are long exposed. Old persons having simply the ordinary senile changes but being fairly healthy otherwise can stand operation very well. Confinement to bed is an important matter in old people. If the injury compels them to lie flat on the back, hypostatic pneumonia may put an end to life. They should be watched carefully and propped up if necessary.

Dr. Randolph Winslow reported SOME CASES OF SEVERE COMPOUND FRACTURE OCCURRING IN YOUNG BOYS. (Soon to be published in the JOURNAL.)

Dr. J. W. Chambers said that children stand shock moderately well. He had recently operated upon a child in its second week for double hair-lip with protrusion of the premaxillary. The child was under the anæsthetic for three quarters of an hour, but there was little or no shock. Children stand loss of blood fully as well as other people. They make blood very rapidly. It is very difficult to say how old people stand shock for the reason that a large number of the old people operated upon are in a pathological condition independent of the condition for which they are operated upon. The tissues of old people heal about as well as those of young persons. If the patient's condition warrants an operation and the heart and lungs and other organs are good, the question of age is hardly a factor.

Dr. J. D. Farrar read a paper upon INTESTINAL ANTISEPSIS IN TYPHOID FEVER

BY MEANS OF BISMUTH SUBIODIDE AND SALOL. (See JOURNAL, page 383.) He commended the plan in practice at the Cooper Hospital, Camden, N. J. He reported a series of 24 cases with no deaths. The bismuth and salol were given in 5 grain doses, alternately, every three hours, night and day. No toxic symptoms from the drugs were noticed. This method of treatment is begun whenever diarrhœa exists and is continued throughout the disease. This treatment is thought to modify the severity if it does not limit the duration of the disease. Tympanites is reduced, diarrhœa controlled and hæmorrhage prevented.

Dr. Norment said that one of the charts exhibited by Dr. Farrar showed the patient to have had a practically normal pulse temperature and respiration upon admission and he thought that the case did not demonstrate so much the benefit of salol and subiodide of bismuth as it did the benefit of convalescence. He thought that further trial was necessary before the utility of the method could be accepted.

1519 N. Broadway. W. T. WATSON, M. D., Secretary.

THE EFFECTS OF EPIDEMIC INFLUENZA ON THE URINARY ORGANS.

At a recent session of the West London Medico-Chirurigical Society, Dr. Fenwick read a paper in reference to effects on the urinary organs observed during, or as a consequence of, epidemic influenza. He observed that the experience of the epidemics of 1890-91 and '92 showed that the influenzal poison is capable of determining affections of the urinary apparatus in persons previously healthy as well as of lighting up affections which had been recovered from in the past or intensifying co-existing maladies of these organs. He alluded in particular to atony of the bladder as the form most frequently met with, usually in young patients who had had a high temperature with stupor in the course of which the bladder had become overdistended without suspicion being aroused. He had met with a considerable number of cases of membrano-prostatic catarrh occurring as a sequel of an attack or of attacks of influenza in persons whose urinary tracts had previously been quite free from any trouble of the kind and he referred in detail to several typical cases, two of which occurred in medical men. Membrano-prostatic catarrh, he said, was well known to be associated with various neuralgic manifestations and these had frequently been complained of. The curious feature of this form of neuralgia is that patients thus afflicted are often unable to travel, the vibration of the omnibus or railway exciting very acute pain. Similar neuralgias were sometimes observed in certain form of poisoning and he suggested that their nature was probably the same.—*Medical Week.*

Last week Nathaniel Polk was committed for Court by Justice Hobbs, charged with obtaining medical works from a number of physicians by false representations. He was charged also with the larceny of a medical book, valued at $4, from Dr. S. T. Earle, 1431 Linden avenue. Drs. J. D. Farrar, Samuel C. Chew, Charles F. Nolen, Lawrence J. Fermelly, C. B. Gamble, J. L. Ingle, John W. Johnson and J. G. Keller testified that Polk, as agent for the Appletons, obtained the subscriptions to medical works which were delivered and paid for, and that he afterward returned to their offices and borrowed the books, saying that he wanted to show them to other physicians. They said that in no case did he return the books.—*Sun.*

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BALTIMORE, MARCH 4, 1893.

Editorial.

FORETHOUGHT.

Among the highest qualities of the human mind must be ranked that of forethought. In every line of human activity, the leading men are those who look beyond the present into the future and prepare themselves for that which they perceive to be impending.

In the political world all thinking men do homage to the wisdom of the framers of our system of government; of that written Constitution which has now stood the test of a century of human progress, and still maintains its position as the model after which modern republics are moulded.

In business life the very pith of many great enterprises is the anticipation of the needs of the time which has not yet arrived, and the pre-emption of posts of vantage against the time when their occupation will bring wealth.

One of the elements of strength in all true religious life lies in its demand for the surrender of immediate and fleeting self-indulgence for the sake of future and permanent good.

In the medical life forethought is equally essential to highest success. In the early years of practice physicians are in many cases strongly tempted to forget the future in the present. Not a few yield, and thus wreck their professional careers. One steps beyond the bounds of regular practice, and betakes himself to self-advertisement; and late in life he bewails his isolation from that professional co-operation and sympathy which is building the fortunes and brightening the weary hours of his more prudent neighbors. Another sells his services to some manufacturing house or to some company of non-professional speculators, and finds himself in a few years the slave of cruel masters who meet his request for better remuneration with the threat that plenty of men are ready to take his place if he wishes to resign. Another "goes into politics," and too often finds himself stranded in middle life without office and without practice.

The whole course of a physician's career cannot be foreseen at the outset; yet each should shape his actions with a reference to what is probably before him in the near future. The days are past in this city we trust when anything but careful preparation, steady work and high principles of daily action will make men successful practitioners. The best practice can no longer, if ever heretofore, be attracted by boastful self-laudation, vulgar habits, unclean garments, offices full of dissecting-room trophies, etc. The young physician, however poor, should train himself from the start in those details of neatness and courteous deportment which will some day make him welcome in the best circles.

Even in these days of alleged overcrowding the supply of well-trained, intelligent, thoughtful, progressive, neat, courteous, temperate, high-principled, tactful physicians of mature age seems never to be in excess of the demand for them. These qualities of character are not acquired after middle life. They are best attained in the "period of struggle," when the class of patients treated seems perhaps hardly to call for their exercise.

THE ARMY MEDICAL BOARD.

This Board will be in session in New York City, N. Y., during April, 1893, for the examination of candidates for appointment to the Medical Corps of the United States Army, to fill existing vacancies. Persons desiring to present themselves for examination by the Board will make application to the Secretary of War, before March 15, 1893, for the necessary invitation, stating the date and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from whence they were graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal knowledge, from at least two physicians of repute, as to professional standing, character and moral habits. The candidate must be between 21 and 28 years of age, and a graduate from a regular medical college, as evidence of which his diploma must be submitted to the Board. Further information regarding the examinations may be obtained by addressing C. Sutherland, Surgeon General U. S. Army, Washington, D. C.

EXTRACTS FROM CIRCULAR.

The Medical Corps of the Army consists of a Surgeon General with the rank of brigadier general, six Assistant Surgeons General with the rank of colonel, ten Deputy Surgeons General with the rank of lieutenant colonel, fifty Surgeons with the rank of major, and one hundred and twenty-five Assistant Surgeons with the rank of 1st lieutenant mounted for the first five years and the rank of captain mounted thereafter until promoted to major. Promotion through the intermediate grades of rank from that of captain to that of colonel is by seniority, but there is an examination for the rank of captain and another for that of major, to ascertain the fitness of the officer for promotion, which must be successfully

passed. Advancement to lieutenant colonel and colonel takes place without further examination. The Surgeon General is selected by the President from among the members of the corps. All vacancies are filled by appointment to the junior grade.

PAY AND EMOLUMENTS.

To each rank is attached a fixed salary, which is received in monthly payments; and this is increased by ten per cent. for each period of five years' service until a maximum of forty per cent. is reached. An Assistant Surgeon with the rank of 1st lieutenant mounted receives $1,600 per annum, or $133.33 monthly. At the end of five years he is promoted to captain and receives $2,000 a year, which with the increase of ten per cent. for five years' service, is $2,200, or $183.33 per month. After ten years' service he receives $2,400, after fifteen years $2,600, and if he remain a captain after twenty years, $2,800 per year. The pay attached to the rank of major is $2,500 a year, which, with ten per cent. added for each five years' service, becomes $3,250 after fifteen years and $3,500 after twenty years. The monthly pay of lieutenant colonel, colonel, and brigadier general is $333.33, $375, and $458.33 respectively. Officers in addition to their pay proper are furnished with a liberal allowance of quarters according to rank, either in kind, or, where no suitable Government building is available, by commutation. When traveling on duty an officer receives four cents per mile and reimbursement of money actually expended for railroad or other fares. On change of station he is entitled to transportation for professional books and papers and a reasonable amount of baggage at Government expense. Mounted officers, including all officers of the Medical Corps, are provided with forage, stabling, and transportation for horses owned and actually kept by them, not exceeding two for all ranks below a brigadier. Groceries and other articles may be purchased from the Commissary and fuel from the Quartermaster's Department at about wholesale cost price. Books and instruments are supplied in abundance for the use of medical officers in the performance of their duties.

EXAMINATIONS.

The mental examinations are conducted by both written and oral questions, to which written and oral answers are required, upon:—

I. Elementary branches of common school education, including English grammar, arithmetic, the history and geography of the United States, natural philosophy, principles of Latin grammar, and upon general literature, ancient and modern history. Candidates claiming especial knowledge of the higher mathematics, ancient or modern languages, drawing, analytical chemistry or other branches of natural science, will be examined in those matters as accomplishments and will receive due credit therefor according to their proficiency.

II. Professional branches, including anatomy, physiology, chemistry, hygiene, pathology and bacteriology, therapeutics and materia medica, surgery, practice of medicine, obstetrics and the diseases of women and children.

Examinations at the bedside will also be conducted in clinical medicine and surgery, and operations and demonstrations upon the cadaver.

Hospital training and practical experience in the practice of medicine, surgery and obstetrics are of great importance to candidates seeking admission to the Medical Corps of the Army, and they will be fully appreciated and duly credited to those who have had such advantages.

The Board has discretion to deviate in such manner as it deems best from this general plan of examination when necessary for the interest of the service.

VACANCIES.

The circular contains also specimens of examination questions in each branch. There are at present ten vacancies in the Corps to be filled.

THE UNIVERSITY OF CHICAGO.

The *Journal of the American Medical Association* reports that a union of two or more of the independent medical colleges of Chicago will probably soon be effected. The Rush Medical College and the College of Physicians and Surgeons have been seriously considering the question of a complete surrender of their properties and an unconditional resignation of their respective faculties in order that a grand medical department may be founded on a level with the other schools of the young and prosperous University. It is said that a million of dollars has been conditionally promised for an endowment fund in medicine, if certain vested interests can be harmonized with the project. Nothing succeeds like success.

Books and Pamphlets Received.

Tumor of Liver in which Removal was Attempted; by JOHN B. ROBERTS, M. D. (Read September 28, 1892.) Reprint from *Transactions Philadelphia County Medical Society.*

Intra-Cranial Neurectomy of Second and Third Divisions of the Fifth Nerve; by JOHN B. ROBERTS, M. D. Reprinted from the *Transactions Philadelphia County Medical Society*, 1892.

Phenate or Carbolate of Cocaine as a Local Anæsthetic; by D. B. KYLE, M. D. Reprint from *Therapeutic Gazette*, January 16, 1893.

The Cosmetic Surgery of the Nose; by JOHN B. ROBERTS, M. D. Reprint from *Journal American Medical Association*, August 20, 1892.

The Treatment of Hay Fever by Means of Cocaine Phenate; by D. B. KYLE, M. D. Reprint from *Medical News*, December 17, 1892.

Piperazin (Scherings) in the Treatment of Stone in the Kidney; by DAVID D. STEWART, M. D. Reprint from *Therapeutic Gazette*, January 16, 1893.

Biennial Report of the Secretary of the State Board of Health of West Virginia; For the years 1891 and 1892. Charleston: Moses W. Donnally, Public Printer.

Alcoholism and its Treatment; by J. E. USHER, M. D.; 8vo., cloth; New York: G. P. Putnam's Sons, 1892.

Hand-book of the Diseases of the Eye and their Treatment; by HENRY R. SWANZY, M. B., F. R. C. S. I. 4th edition, with illustrations; 8vo., cloth. Philadelphia: P. Blackiston, Son & Co. 1012 Walnut St.

Diseases of the Skin, with Special Reference to the Skin Eruptions of Children; by H. Radcliffe Crocker, M. D. (Lond.), Physician for the Diseases of the Skin in University College Hospital, etc. Second Edition, Revised and Enlarged, with 92 wood-cuts. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut St., 1893.

A System of Genito-Urinary Diseases, Syphilology and Dermatology; by various authors, edited by Prince A. Morrow, A. M., M. D., Clinical Professor of Genito-Urinary Diseases in the University of the City of New York. With illustrations. In 3 volumes. Volume, 1 Genito-Urinary Diseases. New York: D. Appleton & Co., 1893.

Medical Progress.

PERITONEAL PERFORATION WITH PAIN.

There is a very interesting article by Dr. Gee, of St. Bartholomew's Hospital, on acute peritoneal diseases, in the *British Medical Journal,* November 12th, in which an extremely graphic description of the above condition is given. Dr. McGee says:

With respect to the symptoms of peritoneal perforation, all cases may be referred to the four types so often spoken of—those characterized by pain, or by ileus, or by shock, and those not characterized at all, the disease being latent; latent, that is to say, so far as concerns the diagnosis.

With reference to perforation characterized by pain the following historical case is vividly illustrative.

A lady had ailed for some time with pain in the stomach and side, but she seemed to be otherwise in good health. One day after dinner she complained several times of pain; she drank some succory water as a stomachic, and putting the cup down with one hand, with the other she pressed her side, and said in a voice which betokened much suffering: "Ha! what a stitch in the side; what pain; I cannot bear it." Speaking these words, she flushed, and a moment afterwards turned pale, with a wan lividity which astonished everybody. She kept crying out, and begged to be carried away, for she could no longer hold up. Supported by the arms of others, she managed to walk, but with difficulty and bent double. Put to bed she cried out more than ever that the pain in the pit of the stomach was past belief; she tossed from side to side. A physician was fetched, who pronounced her complaint colic, and who prescribed suitable remedies. But the pain continued; she said that her pain was greater than could be conceived, and that she would die. All this occurred in less than half an hour. Whatever she swallowed made her retch; she brought up only a little mucus mixed with food. The efforts to vomit and the excessive pain threw her into a state of exhaustion which resembled repose; but she told the bystanders not to deceive themselves, that the pain was as great as ever, and that she had no strength left to cry out. She heard some one remark that she was easier, and she said: "That is so far from being true, that were I not a Christian I would kill myself, so great are my sufferings. It is wrong to wish evil to any," she added, "yet I would that somebody could feel for a moment what I feel, so as to know what my pain is like." Her pulse became imperceptible (*retiré*), her limbs cold; her friends anxiously asked if nothing more could be done; they suggested a score of remedies, and at last her physicians, in sheer desperation, made an attempt to bleed her,

but the blood would not flow. They gave her some broth, for she had taken no food since dinner. She no sooner swallowed it than her sufferings (if not her pain) increased; she complained that her stomach was filling up. Death was painted on her face; the last struggle was short, and after two or three convulsive movements about her mouth she died, nine hours from the beginning of her illness.

This vivid description is taken from an account of the last hours of Henrietta, daughter of Charles the First, written by Madame de Lafayette a century and a half before ulcer of the stomach was known to medicine. An ulcer of the stomach with perforation was discovered by the physicians at the necropsy, but they misunderstood its significance, and it was left to a non-professional attendant to record the case in such a form that after-generations might fathom its meaning.

The case suggests at once the diagnosis of such painful perforation from colic.

The physicians of Madame said that she was suffering from colic, and that a wretched pulse and cold limbs such as hers were common in that disease. I likewise have stood by a patient writhing under the throes consequent upon perforation of the stomach or duodenum, and have asked myself whether there was anything either in the pain or its concomitants which might not occur in intestinal colic, and have been compelled to admit that there was nothing. This difficulty in diagnosis is not to be wondered at if the pain be, as is very likely, in great part due to cramp or painful spasm of the intestines and stomach, and perhaps of the abdominal walls also. Yet our diagnosis may reach a high degree of probability under such conditions as these: The ruptured organ being more often either stomach or duodenum than any other, there may have been some forewarning symptoms of ulcer of one of those parts, the perforation occurring suddenly, so does the pain, and especially after a full meal or an effort, or both. The very acid contents of the stomach poured into the peritoneal cavity are excessively irritant, and the pain is violent in proportion, being far beyond the pain whereof the sufferer has had any experience or conception. The abdominal walls are contracted, tight, and hard, and often very tender. The pain will continue without remission to the end, or will cease altogether, or will only diminish—as I said when speaking of acute peritonitis.

The associated symptoms may or may not assist the diagnosis. Vomiting—often present—is sometimes absent. Some have thought that it is absent in perforation of the stomach especially, but the exceptions to this rule, if it be a rule, are many and of both kinds, namely, rupture of stomach attended by vomiting and rupture of a part not stomach, yet unattended by vomiting. Peritoneal tympanites will ensue if gas escapes into the abdominal cavity, but gas does not always escape, even when some part of the alimentary canal is ruptured. Shock attends the rupture, and usually the extreme prostration persists to the end. When perforation occurs in the course of a febrile disease defervescence is often a marked sign of shock. Suppression of the secretion of urine is common, and seems to be sufficiently explained by the vomiting and the prostration and their necessary consequences—defective absorption and secretion.

RODENT ULCER OF THE MALE BREAST.

At a recent meeting of the Pathological Society of London (*Lancet*, February 4th), Dr. H. B. Robinson showed a specimen of Rodent Ulcer from the Male Breast which was removed by Dr. William Anderson at St. Thomas's Hospital in May, 1890. The patient, aged sixty, had noticed for some years a little swell-

ing on the outer side of the right nipple. About three years previously it had become sore on the surface, exuding a serous slightly blood-stained fluid which dried into crusts. There was some tenderness, but no special pain. In December, 1889, he noticed that the sore was extending and destroying the nipple; its surface was raw and its edges were raised. On admission in May, 1890, there was an irregular ulcerated patch about the size of a half-crown with everted edges. The surrounding tissues were not indurated, and the sore, which extended just beyond the margin of the areola externally, had not quite destroyed the nipple. There were no lymph glands to be detected. The diseased area was removed. The patient died one year later from chronic bronchitis and emphysema without any evidence of recurrence. The growth histologically showed down-growing processes from the rete into the connective tissue spaces. The connective tissue was wonderfully free from round-celled infiltration and the epithelium was never corneous, nor were any cell nests to be met with. The appearances were typically those of a rodent ulcer. In reply to a question Dr. Robinson said that there were some spaces in the cell-collections containing what he believed to be nuclei, but he could not recognize them as psorosperms.

MEDICAL AID ASSOCIATIONS.

This subject has attained such importance in Great Britain, that the General Medical Council has appointed a committee to investigate it. The grievances of the general practitioner against the aid associations are set forth in a remonstrance presented by the Medical Defence Union (*Lancet*), which, it was hoped, would reveal the condition of servitude to which the system carried out by medical aid associations had reduced many honorable members of the profession, who only sought the opportunity to escape from the thraldom into which they had drifted or been driven by stress of circumstances. The condition of affairs was alike derogatory to the honor of the profession and injurious to the best interests of the public. A medical aid association was a business generally formed by the amalgamation of the existing medical clubs in any particular town. Having once amalgamated into a medical aid association they threw open their doors directly or indirectly to any and every comer. But brief consideration was needful to see that the system of these associations was a sweating one. The skill, industry and labor of medical men were made use of to accumulate wealth for what was no more or less than a trading company. The medical man was reduced to a condition of servitude; he was paid a miserable pittance; the greater proportion of his earnings was taken by the proprietors, not only to pay fees but to accumulate assets; the right to freely practise his profession was denied him, or only allowed on consideration that his earnings were divided between himself and his masters. Many, if not most, of these aids did not confine their sphere of operations to these *bona-fide* members of the amalgamated clubs, but practically carried on private and general practice among all comers, not so much for the benefit of the medical officer as for their own emolument. They were, in other words, large unqualified corporations, carrying on medical practice under cover of one or two medical officers, to the destruction of the interests of the resident practitioners of the town. Another way of viewing the same thing was that the surgeon actually paid a tax upon his industry. Many of the associations were good enough to permit their medical officer to attend midwifery cases, but, in consideration of their kindness, they required that a part of the fee should be paid into the exchequer of the association for the benefit of its general funds. Each year the formation of medical aid associations was increas-

ing more and more, and a definite disclosure of policy on the part of the Medical Council would serve not only to bring about a better understanding between the existing associations and their medical officers, but would prevent the extension of what all fair-minded men, both professional and lay, must regard as an iniquitous system.

SYPHILIS AND NERVOUS DISEASE IN CHILDREN.

An interesting discussion of this subject is reported in the *Lancet* from the Medical Society of London; the occasion being a paper by Dr. Hadden, who pointed out that the majority of cases of hemiplegia in young children arose without apparent cause; and that as we find arterial changes in syphilis both of adults, and also, though less frequently, of children we should carefully search for syphilitic history in the cases under discussion.

Dr. Althaus, after referring to the value of the triad of symptoms—the notched teeth, keratitis and median otitis—in the diagnosis of congenital syphilis, made some remarks on the differentiation of this variety from the acquired disease in children. Although the hemiplegia might occur in children in apparent good health, a prolonged watching would rarely fail to be rewarded with the discovery of signs of syphilis. He agreed that mecury alone was often disappointing, but combined with iodide of potassium it gave exceedingly satisfactory results in these cases.

Mr. Sheild remarked that the deafness in children was usually not due to otitis media, but a large majority of them had complete nerve deafness caused by an effusion into the tissues of the labyrinth and auditory nerve.

Dr. Lees said that, looking to the difficulty of proving the presence of syphilis, that affection might act more largely as a cause than could be actually demonstrated; yet, notwithstanding this, he did not believe that it was to a great extent provocative of infantile hemiplegia or of posterior basal meningitis; the latter coexists with syphilis without being actually due to it, and he related a case in which he believed that this relation existed between the two. The fact that many of these cases did better on mercury and iodide of potssium than on any other combination of drugs did not prove that they were necessarily due to syphilis. He related two cases of gummata on the cranial nerves in children, one being in a little boy and the other in a girl aged thirteen. He referred to a third case in a boy aged eight, who had paralytic affection of the lower limbs, and who at first was thought to have spinal caries, but the case ultimately turned out to be one of syphilitic cerebral fibrosis.

Dr. Barlow said that he could recall about six cases of hemiplegia in congenital syphilis, in two of which necropsies were made. In one, a girl aged nine, who had been under observation for five years, there were all the signs of inherited syphilis; she had a convulsion, followed later by the development of hemiplegia, first on one side and then on the other, and she later passed into a state of hebetude. There was found extensive and typical syphilitic disease of all the arteries of the circle of Willis, with marked sclerosis of both hemispheres. He said that the rule was to get generalization of the disease all over the nervous system—first convulsions, local or general, then hemiplegia, perhaps spasm on one side and palsy on the other, then choroiditis, interstitial keratitis, and finally idiocy. Such was the typical course of cerebro-spinal syphilis. The prognosis was always bad, though the symptoms might be relieved by iodide of potassium and mercury. The true basis of observation was morbid anatomy, and it should be remembered that every kind of lesion found in acquired syphilis was found also in the congenital affection, though the distribution was different.

Dr. Walter Carr said that he had made necropsies in six cases of posterior basal meningitis and in none of them was there evidence of congenital syphilis. He considered that the remarkable definiteness of the clinical symptoms and of the pathological lesions of that disease pointed to some definite but at present unknown etiology.

Dr. Wheaton thought that some of Dr. Hadden's cases might be instances of insular sclerosis, either syphilitic or not. He remarked on the prevalence of gummata in children, which were not generally recognized. He thought that one of the commonest lesions in children was an osteitis or necrosis of the bones of the skull. In some cases of hemiplegia with Jacksonian convulsions tubercle was found in the substance of the brain.

GALL STONES.

A paper was read before the West London Medico-Chirurgical Society by Dr. Thudichum on this subject. He referred to his earlier researches, by which he had proved that gall stones were originally caused by catarrh of the mucous glands and epithelium of the bile ducts; this led to the formation of casts of the ducts (drawings shown), and around these, after they had been shed, the gall stone matter was deposited. During the catarrh, bacteria entered the ducts from the duodenum, and caused decomposition of the bile. Foreign bodies were rarely, and the often alleged inspissation of bile never, the cause of gall stones, their real composition being a collection of the products of bile decomposition. A rational medical treatment of gall stones could only be based upon a right appreciation of the functions of the liver and bile. But little progress had been made of late years in this direction, but direct relief was now obtainable by cholecystotomy. Where the bladder was diseased, cholecystectomy should be performed, but this operation involved greater risk. Cholecystenterostomy had its occasional advantages, but was even more risky. In the treatment of colic he advocated the use of morphine subcutaneously, of large quantities of very dilute lemonade, and of chloroform anæsthesia when collapse threatened. Gall stones might be endemic, as in lunatic asylums; thus Mr. Beadles, the assistant medical officer of Colney Hatch, had found gall stones in 36 per cent. of his *post-mortem* examinations of females.—*British Medical Journal.*

Recommendations of Therapeutic Agents.

Iodoform versus Aristol.—Under this head Dr. Richard S. Gibbons, of Scranton, gives a very interesting account of his experience with aristol. The first case in which he employed it was after an operation for the removal of a cancerous mammary gland. The entire wound approximation was dusted with aristol. The lesion was dressed and closed for eight days, when it was found that a complete union had taken place. "Since then," says the author, "I have used aristol for all wound surfaces, exterior and cavital. In all operations about the anus and rectum I have found this remedy of great value."

Dr. Gibbons had equal success with aristol in diseased conditions of the eye, ear, nose, vagina, cervix, the female urethra, etc. He made satisfactory use of it also in supra-pubic cystotomy, and internal urethrotomy. The author adds that: "The powerful effects of aristol to promote rapid cicatrization," led him to employ it for special operations for the relief or cure of malignant disease of the female mammary gland. In the six cases cited, the success achieved was remarkable. Concerning the value of aristol as a protective, Dr. Gibbons writes as fol-

lows: "The results which I have obtained in the use of aristol as a protection to wounds and ulcerated surfaces, and also as a stimulation to granulation, have been satisfactory to an extreme degree." Of its value in cœliotomy he says: "In all cases of abdominal surgery I now use aristol and find it to be the ideal protective, having had no cases of breaking down of the wound of entrance as has happened in several cases where I have used iodoform.—*Times and Register*, Philadelphia.

Medical Items.

Dr. W. W. Moss, of Charlottesville, was married February 23rd to Miss Elizabeth Harmon, a sister of Mr. Daniel Harmon, of the Charlottesville bar.

At the annual meeting of the New York Academy of Medicine, held January 5th, Dr. D. B. St. John Roosa was elected president.

Michigan is removing testicles for mental disease. All cranks will please take notice.

Much merriment has been caused by the report that the Johns Hopkins Medical School was about to consolidate with one of our smaller Baltimore colleges.

A doctor was treating a lady for throat disease. She coughed violently, and he was horrified to see a large mass of clotted blood fly from her mouth. It was not a fatal hæmorrhage, however, but only the dislodgment of her false teeth.

Mrs. Alice Womble Wilbon died February 23rd at the residence of her father, Dr. P. M. Womble, 1532 Bolton Street, of nervous prostration, after an illness of three months. She was the wife of Mr. W. E. Wilbon, of the firm of Tregellas, Hertel & Co. A daughter eight years old survives her.

Dr. Robert C. Rasin was married February 23rd, at twelve o'clock, to Mrs. Robert Millikin, daughter of Mr. R. Q. Taylor, at 601 Lennox St., Baltimore. The ceremony was performed by Rev. William E. Starr, pastor of Corpus Christi Catholic Church. Cardinal Gibbons and Monsignor McColgan were present. The wedding was a quiet one, only members of the families of the couple being in attendance.

It gives us much pleasure to receive, in the form of a reprint on "Atrophic Rhinitis" from the *New York Medical Journal*, November 12, 1892, an intimation that our friend, Dr. Henry M. Wilson, Jr., is flourishing in his new home in Colorado. Dr. Wilson, a son of Dr. Henry M. Wilson, of this city, was compelled for reasons of health to give up the good prospects which spread before him of a successful professional career in Baltimore, and to betake himself to Denver, Colorado, where he confines his practice to the throat and chest.

Although Baltimore, to the salubrity of which he pays a graceful tribute, is the only city in which a man has, in our opinion, all the delights of the highest existence, yet we are glad to trace our friend's success in the home of his exile.

We regret to learn through the daily press that Dr. Albert S. Wagner, resident physician at the Hebrew Hospital, on East Monument Street, near Broadway, died at the hospital, on February 23. Dr. Wagner was in his twenty-fourth year, and his death was caused by pleuro-pneumonia and consumption. He had been resident physician at the hospital since May 1 of last year, and was gradu-

ated from the College of Physicians and Surgeons about a year ago. He was a son of Mr. John Wagner, who lives on the Liberty road, in the northwestern suburbs.

The *Sun* of February 24th states that Dr. C. W. Chancellor, secretary of the Maryland State Board of Health, has been appointed a member of the advisory council of the World's Auxiliary Congress, which will assemble in Chicago May 29 next, in connection with the Columbian Exposition. This early date was chosen to accommodate those who may desire to attend the medical congress to be held in Rome in November. Dr. Chancellor, it is understood, will submit a carefully-prepared report on the climate peculiarities and health resorts of Maryland, in which will be embraced an account of the beneficial effects of the climate of the Eastern Shore of Maryland on consumption.

The formal opening of the new building of the Baltimore Medical College was celebrated on the night of February 24th. This handsome edifice, five stories high, located on the corner of Madison and Garden Streets, has attracted much attention by its fine appearance. Its equipment is in accord with the latest improvements in college architecture.

The building was thronged during the evening by the professors and students and their friends of both sexes, who examined with much interest its halls and laboratories. The structure reflects great credit on the energy and enterprise of the faculty.

The following gentlemen have been duly appointed members of the Advisory Council of Military Medicine and Surgery, of the Pan American Medical Congress: Colonel Louis Read, M. D., Surgeon General, N. G., Pa.; Newton L. Bates, M. D., Medical Director, U. S. N.; J. R. Tyron, M. D., Medical Inspector, U. S. N.; Lieut. Colonel Eustathius Chancellor, M.D., Medical Director, N. G., Mo.; Brv't Lieut. Colonel A. A. Woodhull, M. D., Surgeon, U. S. A.; Major Jos. H. Corson, M. D., Surgeon, U. S. A.; Major Geo. Henderson, M. D., Medical Director, N. G., D. C.; C. N. Hoagland, M. D., Ex-Surgeon, OhioVols.; Bedford Brown, M. D., Ex-Surgeon, C. S. A.; H. C. Goodman, M. D., Ex-Surgeon, U. S. Vols.; Melancthon Storrs, M. D., Ex-Surgeon, Conn. Vols.; O. D. Ball, M. D., Pension Ex-Surgeon, Albany, N. Y.; Captain H. O. Perley, M. D., Assistant Surgeon, U. S. A.; Geo. M. Sternberg, Deputy Surgeon General, U. S. A., President of Section.

At a recent session of the Biological Society of Paris, D. E. Berger stated that the effect of a mixture of several alkaloids is greater than that produced by each substance individually, with less risk of toxic action. He obtained the best results from a collyrium composed as follows: sulphate of atropine 1 per cent. sulphate of duboisine 1 per cent., hydrochlorate of cocaine 2 per cent. This mixture produces a degree of dilatation of the pupils which is obtainable with no other mydriatic. A mixture of .3 per cent. of sulphate of atropine, .3 per cent. of duboisine and 2 per cent. of hydrochlorate of cocaine is at least as powerful a mydriatic as a 1 per cent. solution of atropine, and is less dangerous. A solution containing sulphate of eserine 1 per cent., hydrochlorate of pilocarpine 2 per cent., is an excellent mydriatic and is well-borne by the patients. A mixture of 2 per cent. solutions of hydrochlorate of cocaine and of pilocarpine possesses all the properties of cocaine with this advantage that it does not give rise to dilatation of the pupil and to disturbances of accommodation like a pure solution of that alkaloid.—*The Medical Week.*

In an excellent article on Chronic Rheumatic Joint Affections, in Langenbeck's *Archives*, Professor Max Schueller, of Berlin, discusses their treatment from a medical and surgical standpoint. For these cases which have come to be opprobria medicorum and travel from one physician to the other only to become a prey for the quack and at last eke out a miserable existence, Professor Schueller gives a more hopeful outlook. Among the remedies applied by him, massage and baths are highly commended. With regard to the former he says: "The art of massage is not to be despised by the young physician." If it be his aim, as it should be, to relieve human suffering, to contribute to the sum of human happiness by any means in his power, he must be convinced that here is a field open for him that he may till with pleasure and profit. When a man like Schueller, whose fame as an investigator is only equal to his reputation as a surgeon, does not deem the personal execution of massage beneath his dignity, our young aspirants for practice surely will not shrink from the work, simply because it is now in the hands of men and women who are ignorant of anatomy and physiology. Our cities are filled to overflowing with the latter class. Every physician is besieged by their cards, and many are led to deplore their employment. It would redound to the honor and credit of many of our young medical men if they would master this art.—*Dietetic and Hygienic Gazette.*

The ordinance appropriating $35,000 for the erection of a municipal hospital came up as the special order in the First Branch at the meeting of the City Council last night. The ordinance designates the Mayor, commissioner of health, inspector of buildings, Dr. William H. Welch and Mr. Robert C. Davidson a commission to select the site and prepare plans for the hospital.

Mr. Ogden objected to the passage of the ordinance. He said the measure was imperfect because it did not state how much was to be paid for the land on which to build the hospital. He submitted a letter from Dr. C. W. Chancellor, secretary of the State Board of Health, in opposition to erecting a permanent structure for the hospital.

Mr. Windfelder said: "We don't want to wait for an epidemic for the erection of such a building. We want it now."

Mr. Guyton asked how many physicians had recommended the permanent structure before the Council committee. Mr. Windfelder replied that about twenty had done so.

Mr. Smith spoke in favor of the ordinance.

Mr. Fahey moved to postpone the matter until next Monday. The motion was rejected by a vote of 10 to 11. Mr. Guyton offered an amendment that the appropriation include both the money for the lot and for the erection of a building. The amendment prevailed and the ordinance was then rejected by a vote of 10 yeas and 11 nays.

Those who voted for the ordinance were: Messrs. Seim, Barnes, Windfelder, Guyton, Leonard, Craig, Berry, Fahey, Snyder and Smith. Those who voted against it were Messrs. Manken, Deuport, Stewart, Rigger, Doyle, Schleifer, C. W. Brown, Gehring, Spindler, Ogden and M. B. Brown.

The ordinance appropriating $10,000 for a steam disinfecting plant was, on motion of Mr. Windfelder, referred back to the committee on health.—*Sun*, February 28th.

The defeat of this ordinance may be explained by the fact that there was "nothing in it" for the politicians.

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SOME SEVERE CASES OF COMPOUND FRACTURE IN YOUNG BOYS.*

BY RANDOLPH WINSLOW, M. D.,

Professor of Anatomy and Clinical Surgery in the University of Maryland; and of the Principles of Surgery, in the Woman's Medical College of Baltimore.

CASE I. *Compound Fracture of Tibia; Recovery.*—On November 23rd, 1890, Harry Robinson, white, aged seven years, was admitted to the Hospital of the Good Samaritan, Baltimore. On the preceding day, whilst riding upon a load of hay, the little fellow slipped off, and in falling ran his leg between the spokes of a revolving wheel. He was violently dashed to the ground, and sustained a severe compound fracture of the left leg. My friend, Dr. W. S. Maxwell, of Kent Co., Md., was called in, and finding the child seriously injured, wisely decided to place him in a hospital for treatment. He was temporarily done up, and sent to Baltimore on the first steamer. Upon admission he was found to have sustained a fracture of the tibia about the junction of the upper and middle thirds, the soft parts were extensively torn from the bone on the front of the leg, and the laceration continued about six inches down the limb on its anterior aspect, and then passed transversely around the leg to its posterior surface, leaving a large exposed surface. The fracture ran in an oblique direction and the periosteum was entirely detached from the upper fragment. There had

*Read before the Clinical Society of Maryland, February 3rd, 1893.

been considerable hæmorrhage, which had ceased when he arrived. He was placed under chloroform, and the wound carefully cleansed of all foreign matter, clots, etc., and disinfected with a strong solution of corrosive sublimate. As the upper fragment was tilted upwards by the action of the quadriceps extensor muscle and could not easily be held in apposition with the lower fragment, the bones were drilled and held together with silver wire. The soft parts were accurately sutured, and an antiseptic dressing applied, and then a side splint. The boy did well, there was but little reaction, the wounds healed kindly, and consolidation of the fracture took place. At the lower angle of the skin wound, however, granulations became exuberant, and necrosed bone was detected, which soon protruded through the opening at that point.

On January 29th, 1891, a sequestrum 1½ inches in length was removed, leaving a smooth granulating cavity, which promptly healed. The whole thickness of the shaft of the tibia necrosed, but the continuity of the bone had been restored by the separated periosteum, and he left for home in about three months from the time of injury. This was an exceedingly unpromising case, received for treatment 24 hours after injury, the patient a frail-looking little boy, brought in on a mattress, with his leg wrapped in bloody bandages, enveloped in a pillow, the upper fragment absolutely denuded of periosteum, and sticking out of the wound. It admirably illustrates the recuperative powers of the young. When admitted his temperature was 101½, falling to normal about the 5th or 6th day.

Case II. *Compound Fracture of the Pelvis, Extensive Laceration of Soft Parts. Recovery.*—Henry Kolosky, white, age 12, schoolboy, was admitted to University Hospital, Baltimore, on July 12th, 1891. His family history is good, and there is nothing to note in regard to previous personal history. On Sunday, July 12th, he went with some companions to an old mill on the Frederick road, and began to ride on the wooden water wheel. The wheel revolved in such a manner as to catch the boy between a rafter and the wheel, causing extensive injuries. He was brought to the hospital in a condition of shock. A piece of timber had penetrated the floor of the pelvis, behind the scrotum and to the left of the anus, producing an extensive laceration of the soft parts; the rectum was exposed in the wound, as were the urethra and bladder, but fortunately they were not injured; the pubic bone on the left side was fractured near the symphysis, and widely separated, and the abdominal walls were extensively lacerated, so that the hand could be passed under the abdominal muscles, and feel the intestines, with only the peritoneum intervening. Several pieces of wood were removed from the wound. The wound was carefully cleansed and irrigated with bichloride of mercury solution, the abdominal walls pierced and a long drainage tube carried from the crest of the ilium along the whole track of the laceration and brought out near the anus; the wounds were not sutured, but were packed with iodoform gauze, and an iodoform gauze dressing applied externally. The fracture was adjusted as well as possible, and a long splint applied from axilla to foot, and the pelvis firmly bandaged. His death was expected, but his recovery was rapid.

For a few days he complained greatly of pain in his belly, but this soon passed off. After he had been in hospital about two weeks, it was seen that the pelvic bones were too widely separated; an incision was made, and the bones drilled and brought together with silver wire. After this, consolidation took place very rapidly, and he was discharged absolutely well on September 3rd, 1891, less than eight weeks from the time of his injury. During the first week his temperature fluctuated between 102 and 99°; for the second and third weeks it was about 99, and subsequently remained about normal.

Case III. *Compound Diastasis of Lower End of Femur; Recovery.*—Mattie Staub, white, age seven, was admitted to University Hospital on September 21st, 1891. He is a chubby, healthy boy, who was struck by cars at this date and sustained a diastasis or separation of the inferior epiphysis of the left femur, with laceration of the soft parts communicating with the bone, besides a flesh wound and contusion of the right leg and left shoulder, and the evulsion of three nails from the left hand. The injury was very severe. The displacement of the bones was corrected by wiring, the wound carefully disinfected and drained, dressed with iodoform gauze and sterilized cotton and put up in a plaster of Paris splint, with an opening at the knee to allow the changing of the dressing. The subsequent history is almost uneventful. When the dressing became soiled, or the temperature elevated, a new dressing was applied. Owing to the necessity for rather frequent redressings, a long side splint was substituted for the plaster of Paris casing, and all the apparatus was removed on December 5, 1891. He was discharged well February 11, 1892, with no shortening or disability. His temperature usually remained 99°, but occasionally went up, only to promptly descend when the wound was redressed. This is a very interesting and instructive case. Separation of the end of the femur from the shaft is quite a rare injury, but we should always bear in mind the possibility of this accident in children and youths. Of course a compound diastasis is a much more severe and dangerous lesion than a simple one. The only other diastasis of the femur which has come under my notice was not compound.

Case IV. *Compound, Comminuted Fracture of the Upper Third of the Femur; Recovery.*—Willie Dash, white, aged ten years, admitted to the University Hospital on September 27, 1891. Family history good, previous personal history unimportant. At the above date he fell from a willow tree to the ground, sustaining a compound comminuted fracture of the upper third of the right femur. There was extensive laceration of the soft parts and the femur was broken into three pieces. One piece was triangular in shape, and was entirely detached from the rest of the tissues. As it was impossible to keep the fragments in apposition, they were wired together, including the loose triangular piece, and the soft parts were sutured *without drainage.* This was an experiment which was watched with great interest, as it was expected that the loose portion of bone would necrose and cause trouble. Such was not the case, however, as the bones united promptly and the soft parts healed without suppuration. A fenestrated plaster of Paris

splint was applied over an antiseptic dressing. He had also many bruises distributed over the body. He did not suffer severely and on the third day he was quite comfortable. There was some tendency to shortening, and an extension apparatus was applied, which was subsequently replaced with a long splint. The wound healed practically under one or two dressings, and the stitches were not removed for thirty days. The patient left the hospital December 5th, 1891, with his bones firmly united and the wound healed, two months and two days from the time of his entrance. I call attention especially to the union of the fracture, one piece having been entirely detached, removed, cleaned and wired in position, and to the speedy and satisfactory healing of the extensive lacerated wound without drainage and without suppuration. During the first week the temperature varied between 97⅗ and 102°, subsequently becoming and remaining normal.

Case V.—Samuel Rabinowich, white, age 12, admitted to the University Hospital on December 20, 1891. Family and previous personal history good. The patient, a newsboy, in jumping from the grip car of the traction road was thrown to the ground, and the trail car passed over his left leg, producing a compound transverse fracture of the tibia and fibula about the middle third. The skin wound was longitudinal on the inner side of the tibia, extending from an inch of the ankle within two inches of the head of the tibia. The ends of the broken bones protruded from the gaping wound. After careful cleansing with antiseptic solutions, the bones were wired together, the wound sutured without drainage and an antiseptic dressing applied. A rigid splint was applied over the dressings. Reaction from the shock soon occurred, and with the exception of some pain, he was soon doing phenomenally well. The first dressing was not removed for six weeks;the bones were found to be united, and the wounds nearly healed. The stitches were removed at this time. The temperature reached 101⅘ ° during the first week and remained nearly normal subsequently, except during the eighth week, when it reached 104⅗ ° from an attack of grippe. He left the hospital well on March 14, 1892, and is now suing the railroad company for damages.

Case VI. *Crush of Both Legs by a Car Passing over Them; Double Amputation; Recovery.*—Daniel Kearney, white, age 16, native of Portsmouth, N. H., was admitted to University Hospital November 1st, 1891. He had run away from home, and while stealing a ride, fell from the car and the wheels passed transversely over both of his legs, almost severing them, and extensively mashing the tissues. He was brought to the hospital in a state of profound shock, and beyond cleansing the parts and surrounding the legs with antiseptic towels, nothing was done to the limbs. Hot bottles were placed around him, and stimulants administered. He was admitted about 1 o'clock P. M., and it was about 8 P. M. before it was thought proper to operate. A double amputation was then performed in the upper third as rapidly as possible, but he almost died from shock. He was placed in bed and efforts were made to stimulate his flagging powers. The shock was long continued but eventually reaction was accomplished, and he did well. One stump healed promptly, but slight sloughing of the flaps occurred in the

other, which, however, healed well somewhat later. He recovered perfectly and returned to his home in New Hampshire.

Case VII. *Railroad Crush of Left Femur; Amputation at Hip-Joint; Death.*—Johnson Ridge, white, age thirteen years, was admitted to the University Hospital August 12, 1892. In attempting to board a train at Edgemont, Washington County, Md., he slipped and the wheel passed over his left thigh, completely severing it, a few inches below the hip-joint. The accident occurred about 4 P. M., August 11th. He was put in a freight car and sent to Baltimore, reaching the hospital about 8.30 in the morning. His pulse was fairly good, and he was cleaned, shaved, disinfected, and hot bichloride towels wrapped around the limb, and put to bed. Stimulants were freely administered. At eleven o'clock the limb was amputated at the hip-joint by the Jordan method. An interesting feature was the complete obliteration of the femoral artery, which was entirely sealed with a thrombus. The operation was performed quite quickly, but the boy went into collapse, and notwithstanding the hypodermic injection of whiskey, strychnia and nitroglycerine, he died about three or four hours after the amputation.

It is a question to my mind whether a patient in the condition of this one would not stand a better chance of recovery, if he was simply dressed antiseptically and let alone until reaction had taken place thoroughly, though the condition of the heart-action seemed to warrant the operation.

Compound fractures differ from simple ones in several particulars, primarily and most obviously in the fact that to a break of the bone there is super-added a wound of the soft parts communicating with the fracture. Another very marked difference between simple and compound fractures is the liability of the latter to have dirt and foreign bodies of various kinds entangled in the wound, which is impossible in the simple varieties, besides the much greater opportunities which are afforded for infection to occur in the compound fracture, as tetanus, suppuration, septicæmia, etc. It has been also a matter of observation from remote times to the present day that a compound fracture requires a longer period for repair to take place than does the simple variety. In many cases the mechanical problems involved in the treatment of the open fractures are very much more complicated than in simple fractures. Lastly, the mortality of the compound is much greater than in the simple variety. All these factors render these injuries interesting and instructive to the practitioner. It was formerly said that it would require about as many weeks for the healing of a compound fracture as it required days for the repair of a simple fracture, as a prolonged period of fever and suppuration was the usual result. This statement no longer holds good in practice, since under the antiseptic regime, most compound fractures may be healed nearly as quickly and as safely as simple fractures of equal severity. Whilst it is easy to epitomize the treatmentof fractures into the sentence, "reduce the fracture and keep it reduced," nevertheless in practice this is often a very difficult matter, which requires the exercise of all the ingenuity of which the surgeon is possessed, and in compound fractures this is especially true, as the existence of a wound

more or less extensive very materially increases the difficulties of the case. When a case of compound fracture of the lower extremity is brought to the University Hospital during my service, the patient is placed under an anæsthetic, usually ether, and his wound and limb are thoroughly washed with soap and water, scrubbed with a stiff brush and the surrounding parts shaved. All dirt is removed from the tissues as far as is possible, and the wound is thoroughly irrigated with hot sublimate solution, about 1-3000. All the recesses and pockets of the wound are thoroughly irrigated or douched with large quantities of sublimate solution. The bones are adjusted, and if there is any tendency to displacement, they are drilled and wired together with silver wire. The soft parts are sutured loosely if there has been much contusion or laceration of the tissues; tightly if the wound is clean cut. Drainage is instituted if there is a probability of the occurrence of gangrene, otherwise drainage tubes are dispensed with. A dressing of sterilized iodoform gauze and absorbent cotton is applied, or of simple sterilized gauze, and usually over this a plaster of Paris splint. In fractures of the femur an extension apparatus is usually employed, or Hamilton's long side splint, extending from the axilla to below the foot. We redress the wounds only when some indication is present, such as soaked dressings, severe pain and, above all, an elevation of temperature. The thermometer is our usual guide for interference; as long as the temperature continues normal or nearly so, the parts may be left alone; when the temperature ascends we open the dressings and seek for the cause. The question of amputation in these injuries is a serious one, and should only be answered in the affirmative when the main blood vessels are injured and gangrene impending or when the soft parts are extensively destroyed.

No. 1 Mt. Royal Terrace.

A CASE OF CROUPOUS PNEUMONIA COMPLICATED BY THE INCUBATIVE STAGE OF MEASLES.

BY ALEX. L. HODGDON, M. D., OF BALTIMORE.

Was called to see J. C., aged six years, and found that initial chill, marked nervous symptoms, implication of right lung, temperature of about 104½ degrees F., rusty-colored sputa and severe pains in right side had ushered in croupous pneumonia; crisis was completed and temperature normal by about the seventh day, leaving the patient feeling quite comfortable.

In about 24 hours later, the temperature began to rise and on the 12th day an eruption appeared on the body, associated with painful eyes and coryza, which I found to be the eruption of measles, which, by the 16th day, had pretty nearly disappeared, and had left the little patient free from fever. The child had probably been exposed to measles a few days before the pneumonia developed; and the whole course of the pneumonia was complicated by the incubation stage of the measles.

About the third day of the pneumonia, an abortive attempt was made at a crisis—the temperature falling nearly to normal, and rising again as high as before.

1235 Lafayette Ave.

THE MARYLAND MEDICAL JOURNAL.

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A. K. BOND, M. D., Editor.

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BALTIMORE, MARCH 11, 1893.

Editorial.

PROFESSIONAL UNIFICATION.

We are requested to call attention to a feature in the plan of the coming Pan-American Medical Congress expressed in By-Law XI, given in this issue.

Its aim is to draw into closer union all medical, dental and pharmaceutical organizations upon the continent of America.

It throws open the floor of the Congress to the members of all organizations of the three professions mentioned, who shall comply with the simple terms stated; and accepts the organizations themselves as "constituent bodies" of the Congress, giving them the right to send delegates. The simple conditions, that the constituent bodies shall not hold their regular meetings at the same time and place with the Congress, that due notice shall be given of the desire for representation etc., cannot hinder any society wishing to become a "constituent."

We infer, of course, that such "delegates" will be required to pay the usual membership fees.

We invite the attention of our State Faculty and city societies to this matter; and hope that Maryland will enthusiastically claim her place among the commonwealths of the Western Hemisphere, and be fully represented at the sessions of the first congress of the medical professions of the three Americas.

The Congress is to be congratulated on its guidance by men of wise and far-reaching counsel.

THE WOMAN'S MEDICAL JOURNAL.

This new publication modestly claims a place, as but a rose-leaf in the already full cup of medical journalism. With femininity regnant in its councils, it is of course neat in its guise and attractive in its contents.

We hope that it may indeed add new fragrance to the waters of professional literature. May it never be soiled by the commercialism and quackery which have so tainted the cup; nor lose its sweetness in the insipidity of wordy talk; nor languish for want of cash subscriptions.

The publication address, etc., of this new journal is given in our column of "Publications Received" in this issue.

THE PAN-AMERICAN CONGRESS.

The matter sent us from week to week by the management of the Congress is so extensive and of such importance and interest to the profession, that we shall hereafter set apart a special column under which all such matter may appear.

The management has honored us by appointing this Journal as one of the organs of the Congress; and has honored our State very highly in the number of officers and official representatives chosen from her medical ranks.

We take pleasure therefore in testifying our appreciation of such courtesy by giving abundant and prominent notice to the preliminary announcements forwarded to us.

Reviews, Books and Pamphlets.

Lectures on Mental Diseases; Designed Especially for Medical Students and General Practitioners; by HENRY PUTNAM STEARNS, A. M., M. D., Physician-Superintendent of the Hartford Retreat, Lecturer on Mental Diseases in Yale University, etc. P. Blackiston, Son & Co., Philadelphia, 1893. Price $3.

In the volume now before us, the author has tried to give in a comprehensive but not too voluminous work enough of the subject of insanity for the use of the general practitioner, that by the knowledge of its contents he would be enabled to make his diagnosis in any given case of mental trouble. In this the author has succeeded. The arrangement of the subject matter is both convenient and valuable. It leads the student from a study of the brain anatomically to its functions physiologically, giving the views of most recent authority up to the derangement of its normal action as the initial element of insanity.

After devoting a few lectures on the elements of insanity, the different phases of mind disease are treated in the order of their frequency, with many practical illustrations from the author's own observation. As in very few medical schools in the United States lectures on insanity are given, this book fills a want especially for the student. A very useful appendix contains extracts from the laws of the different States and territories of the United States which relate to the general care of the insane; especially those relating to the duties and responsibilities of physicians and officers of the law in reference to committing insane persons to institutions for care and treatment.

Medical Notes in Egypt; by FREDERICK PETERSON, M. D., Professor of Nervous Diseases in the University of Vermont; Chief of Clinic, Nervous Department, College of Physicians and Surgeons, New York, etc. M. J. Rooney, Printer and Publisher, 114 W. 30th St., New York, 1893.

This is an interesting collection of articles on "Wintering in Egypt," "The

Baths of Helwan" and "The Insane in Egypt," originally published in the *New York Medical Journal* and *Medical Record* in May, June and August, 1892.

The Woman's Medical Journal. A monthly journal devoted to the interests of Women Physicians, E. M. Roys-Gavitt, M. D., Editor-in-Chief, Claudia Q. Murphy, Managing Editor. Vol. 1, No. 1, January, 1893. Address business communications to Margaret L. Hackedorn, business manager. *The Recorder* Publishing Co., Toledo, Ohio. (See Editorial Column.)

Books and Pamphlets Received.

"Oils and Fats" in Surgical Dressings; by DR. C. M. HOBBY, Iowa City. Reprint from *Transactions of Iowa State Medical Society,* 1892.

The Retention of Binocular Vision with Two Glasses of Different Strengths; by ARTHUR D. MANSFIELD, M. D., Baltimore. Reprinted from *Annals of Ophthalmology and Otology,* Volume II, No. 1, January, 1893.

A New Measurement in the Study of Fever; by LOUIS F. BISHOP, A. M., M. D., of New York. Reprint from *Medical News,* January 28, 1893. This is a plea for the adoption of the "hour-degree," a unit expressing the "quantity" of fever, gained by multiplying its various altitudes by its duration.

Abstract of Proceedings of the Michigan State Board of Health; Regular Meeting Jannary 13, 1893.

Transactions of the American Ophthalmological Society, 28th Annual Meeting; at New London, Connecticut, 1892. Hartford, published by the Society, 1892.

International Clinics; Volume IV, 2nd Series, 1893. Philadelphia: J. B. Lippincott Co., 1893. Cloth.

Special Consular Reports of U. S.; Fire and Building Regulations of Foreign Countries; from Bureau of Statistics, Department of State. Washington: Government Printing Office, 1892.

Special Consular Reports of U. S.; Australasian Sheep and Wool; from Bureau of Statistics, Department of State. Washington: Government Printing Office, 1892.

Hypnotism as a Therapeutic Agent; a Paper Read at the 23rd Session of the Virginia State Medical Society; by WM. LEE HOWARD, M. D., of Baltimore. American Job Office, 1893.

International Congress at Rome.

The Eleventh International Congress of Medicine will be inaugurated in the presence of the King of Italy in Rome, on the 24th of September, 1893, and will close on the 1st of October.

Any physician may become an active member of the Congress by fulfilling the conditions of membership, inscribing his name, and securing his admission ticket.

Scientists of other professions who, through their special studies, are interested in the labors of the Congress, may acquire the rights and assume the duties of active members, and participate in the work of the Congress, both by communications and discussions.

The fee for admission to the Congress is twenty-five francs, or five dollars. It entitles to a copy of the Transactions of the Congress, which will be forwarded to the members immediately after publication.

Papers for and communications to the Congress must be announced on or before June 30, 1893. A brief abstract of every paper and communication, with their conclusions, must be sent to the committee on or before July 31st. All of them will be printed and distributed to the members by authority of the president. Such as arrive after that date cannot be expected to find a place on the regular order of business, and will be accepted only if time will permit.

Fifteen minutes are allowed for the reading of a paper or communication. In the discussion every speaker can have the floor but once, and for five minutes only. To close the discussion the author of the paper is allowed ten minutes. Additional time may be given him by the president by special resolution.

Such members as participated in the discussion, are required to hand to the secretaries their remarks, in writing.

The official languages of the sessions are Italian, French, English and German. The regulations, programmes and daily bulletins will be published in the above four languages. During the meeting, however, a member may be permitted to use, for a brief remark, any other language, provided some member present express his willingness to translate such remarks into any of the official languages.

The president may invite or admit students of medicine to attend and to listen. They will be given a special admission ticket, free of charge.

The provisional committee has made arrangements with the different Italian and foreign railway and navigation companies, in pursuance whereof special reduced prices have been granted on the steamers and railways of this country and of the countries which the members of the Congress are to traverse.

In Italy the members of Congress will find tickets for round trips, starting from Rome; they will thereby be enabled to visit the most important cities and the various universities. In regard to this, further notice will be given.

The ladies of the members will be furnished ladies' tickets, which will entitle them to the reduced fares granted to the members, and to participate in the festivities connected with the Congress.

On the occasion of the Eleventh International Medical Congress, an International Exhibition of Medicine and Hygiene will be inaugurated in Rome, which will gather all that may practically interest physicians and specialists. A special committee has already insured the co-operation of all the most important manufacturers of the world.

The members of the American National Committee are the following: W. T. Briggs, Nashville, Tenn.; H. P. Bowditch, Boston, Mass.; S. C. Busey, Washington, D. C.; C. Cushing, San Francisco, Cal.; N. S. Davis, Chicago, Ill.; Norman W. Kingsley, D. D. C., New York; William Osler, Baltimore, Md.; Wm. Pepper, Philadelphia, Pa.; F. Peyre Porcher, Charleston, S. C.; Charles A. L. Reed, Cincinnati, O.; D. B. St. John Roosa, New York; Alex. J. C. Skene, Brooklyn, New York; James Stewart, Montreal, Can.; A. Jacobi, New York, Chairman.

It is the earnest wish of the Central Committee to receive applications at an early date. The admission fee of five dollars may be sent to the Treasurer, Professor L. Pagliani, of Rome, Italy; in return, the ticket of membership will be forwarded. It is requested that a visiting card, containing name and address,

be sent with each application, to facilitate exact spelling. The Chairman, Dr. A. Jacobi, 110 W. 34th Street, New York, offers his services to whoever will direct him to forward both application and fee.

Pan-American Congress.

In reply to an open letter from Professor Czerny, of Heidelberg, Dr. Reed, Secretary General, P. A. M. C., and others in charge, make the following official statements:

A careful reading of your valued communication leads me to the conclusion that you in common with other distinguished German *savants* hesitate in accepting an invitation to attend the Pan-American Medical Congress, (1) because the German profession is not officially invited by the Executive Committee to become a constituent part of the Congress; (2) because the German language is not one of the official languages of the Congress, and (3) because a general participation on the part of yourself and confreres might be construed into disloyalty to the International Medical Congress which is to meet in Rome in the same month.

In reply I beg to state that the occasion for holding a medical Congress in the United States in 1893 is the fact that a large number of physicians will be in this country in attendance upon the World's Columbian Exposition. This attendance will be largely, although not by any means exclusively, from the countries of the Western Hemisphere. It would have been very desirable indeed to have arranged an organization which would have embraced all the countries of the world. The medical profession of the United States, however, acknowledges allegiance to the World's International Congress which is to meet in Rome. To have attempted an organization in Germany or any other European countries in the interest of the American meeting would have been in violation of our loyalty to the International Congress, while an official invitation to have government and medical societies of Germany and other European countries to send delegates to the Washington meeting would have been almost equally inimical to the interests of the Rome Congress. It was therefore resolved that the organization should be limited to the American countries and that while it was desirable to secure the attendance of our distinguished confreres from Europe as guests, invitations to that end should be strictly personal in character, and should be issued by the general officers and presidents of the sections, at their discretion.

The languages chiefly spoken by the peoples of the various constituent countries of the Congress are Spanish, Portuguese and English, and these were accordingly selected by the Committee as the official languages of the Congress. French, which is the language of important colonies and communities, was subsequently added, at the instance of our confreres in Brazil, who employ it largely in scientific communication, as, indeed, do a large proportion of the physicians of both the English and Spanish-speaking countries. Danish and Dutch are not included, simply for the reason that it is extremely, indeed practically, impossible to deal with them satisfactorily in a literary way in this country. It was hoped that delegates from countries and colonies speaking other than Spanish, Portuguese, English and French would furnish their remarks on papers in one of the official languages. This was so thoroughly understood by the committee and has become such a well-established usage at international congresses, that it was not deemed necessary to state it explicitly; but I shall communicate the suggestion which you kindly make to the Executive Committee, when I have no doubt it will be made definite in the By-Laws.

As early as December, 1891, I opened correspondence by telegraph with the President of the Eleventh International Congress, and subsequently with Professor Maragliano, of Genoa, the Secretary-General, asking that the date of the Rome meeting be arranged so as to permit us to send delegates from Washington. The date of the International Congress was accordingly changed from the 17th to the 24th of September, which will give us sixteen days in which to go from Washington to Rome. Arrangements were begun in February of last year for a special sailing steamer September 9th, direct to Italy, by the way of Azores and Gibraltar, to take those desiring to attend the Rome meeting, a special reduced rate being accorded for the occasion. My present correspondence indicates that a large number will avail themselves of this privilege. It is highly gratifying to note that the expediency of this plan has occurred quite independently to one so conversant with affairs as yourself.

Permit me to say in conclusion that our European confreres who may honor the Pan-American Medical Congress with their presence will be accorded every linguistic privilege, that arrangements have already been made for their return to Italy in time for the International Congress, and that in the event of their coming they will be greeted with a most cordial American welcome.

SECTION ON MEDICAL PEDAGOGICS.

The Pedagogic section will devote its attention especially to the history of the development of medical education in America. In the papers presented by leading teachers, recent advances in methods of instruction will be considered.

The art of teaching, which is regarded as a study of great interest in other branches of learning, has received hitherto but little attention from the medical profession.

The section in medical pedagogics will therefore be made a prominent feature of the Congress and it is hoped that those interested in medical education will co-operate in the work of this section by being present and by actively engaging in the discussion of subjects presented.

Any inquiries or communications may be made through the secretaries undersigned: J. Collins Warren, M. D., Executive President, Boston, Mass.; Charles L. Scudder, M. D., English-speaking Secretary, Boston, Mass.; Wm. F. Hutchinson, M. D., Spanish-speaking Secretary, Providence, R. I.

NEW BY-LAWS.

Languages.—By-Law IX: Papers may be read in any language providing that authors of the same shall furnish the Secretary-General with an abstract not exceeding six hundred words in length in either of the official languages (English, Spanish, French or Portuguese), by not later than July 10th, 1893, and providing, further, that a copy of each such paper shall be furnished in either of the above languages, at or before the time of the meeting, to the Secretary of the section before which the same shall be read. Remarks upon papers may be made in any language, providing that members making such remarks shall furnish a copy of the same in either of the official languages before the adjournment of the session.

Publication.—By-Law X: All papers read in full or by title shall be immediately submitted for publication in the transactions (Special Regulation 3), but authors may retain copies and publish same at their pleasure after the adjournment of the Congress.

Constituent Organizations.—By-Law XI: All medical, dental and pharmaceutical organizations, the titles of which have been transmitted with approval to the

Organization Committee or which may be transmitted with approval to the Executive Committee by any member of the International Executive Committee, each for his own country, shall be subject to election by the Executive Committee, approved by the President, as constituent bodies of the First Pan-American Medical Congress and each organization thus constituted shall have the right to designate as delegates all of its members attending the Congress, but no such organization shall meet at the time and place of meeting of the Congress as a distinct body; providing, that the Secretary of each such constituent body shall furnish a list of officers and a statement of the number of members of his respective organization to the Secretary-General not later than sixty days before the meeting of the Congress, and shall forward a list of delegates chosen to reach the Secretary-General before the opening of the Congress.

Medical Progress.

"RETURN CASES" OF SCARLATINA.

A physician writing to the *British Medical Journal*, January 7, brings up an interesting point in regard to the contagion of scarlatina which we have not before seen mentioned. He says: I am medical superintendent of an infectious hospital about fourteen miles south of London, and have great difficulty in dealing with "return" cases. By these cases I mean cases of scarlatina occurring in the same household after the return home of a patient from the hospital. All patients are kept in the hospital at least eight weeks, and are sent out free from desquamation and free from eruption or discharge, and yet apparently they communicate infection to others, who in turn come into the hospital with scarlatina, and are called "return" cases. These "return" cases occur frequently in London, but in the country over each occurrence of this nature there is an investigation, and such suspicion of negligence on my part that my position of medical superintendent is rendered almost unbearable. I believe the period at which scarlatina is most infectious is during desquamation, but owing to the frequency of these "return" cases, I am often inclined to think that the next most infectious period is after desquamation has been completed. These "return" cases cause me such great distress that I venture to ask your advice and to invite the opinion of your correspondents on the matter.

DRESSINGS OF WOUNDS.

In an interesting series of articles on this subject, Dr. Lister, the pioneer of antiseptic surgery, says (*British Medical Journal*, February 11):

For dressing the wound in the absence of chemical antiseptics, dry substances, such as absorbent cotton, wool or old linen (preferably boiled before use), are far better than anything kept permanently moist, like water-dressing. It was shown several years ago by Naegeli of Munich that the more concentrated an organic solution is, the less easily do bacteria develop in it, much in the same sort of way as a cook who makes her jam has to boil it down until the syrup has a sufficient proportion of sugar in it, or else fungi will develop in the preserve. And so the blood and serum oozing into a dry dressing, becoming more or less inspissated by evaporation, are in proportion a less favorable soil for microbic development. If we look back to our old experiences with water-dressing, we can only wonder that wounds ever united by first intention at all under such treatment. This water-dressing, clean at the moment of application, was invari-

ably stinking when it was taken off in the course of twenty-four hours; and it seems astonishing that septic mischief ever failed to develop in a wound with this putrid mass lying over its outlet. It only serves to illustrate how powerful are the means by which nature defends herself against the microbes.

But with dry dressing, in conjunction with the care in other respects which I have referred to, you would find that complete primary union, instead of being a rarity as formerly, would be a matter of very frequent occurrence; although you would not be at all able to reckon upon the constancy of aseptic results which may be obtained by the right use of chemical antiseptics.

Iodoform is an agent very much trusted by some surgeons. It is a very peculiar antiseptic, having extremely little influence over the growth of bacteria outside the body. That was illustrated by a very simple experiment I performed a good many years ago. I took two purified stoppered bottles, and put into one of them cotton wool strongly impregnated with iodoform—ten per cent. iodoform wool; and into the other ordinary absorbent wool. I poured milk from a dairy into each, just sufficient to soak the mass of cotton, and left them at the temperature of the air. In one of these bottles the milk was thus most intimately associated with iodoform, yet it soured like that in the other bottle, though somewhat later, and when I examined a little of the iodoform wool under the microscope, I found the milk which it contained teeming with bacteria of different species. That simple experiment was enough to show how little power iodoform exerts over the growth of microbes outside of the body. This conclusion has since been amply confirmed by the observations of others. It has even been ascertained, as a matter of experiment, that if iodoform is dusted over sterilized cultivating jelly in a test tube, growth will take place from organisms that were contained in the iodoform itself.

But though such is the case, it is nevertheless unquestionably true that iodoform exercises a powerful antiseptic influence upon wounds. The most probable explanation of this apparent anomaly is that suggested by Behring, namely, that iodoform produces its beneficial effects, not by acting directly upon the bacteria, but by inducing chemical changes in their toxic products. Behring has ascertained as a matter of fact that some of these toxines are altered chemically by iodoform and at the same time rendered harmless. Two of his experiments, performed in conjunction with De Ruyter, may be quoted in illustration. A ptomaine obtained from a culture of pyogenic micrococci killed a mouse in twelve hours when injected pure into the peritoneal cavity, but proved entirely harmless under similar circumstances when mixed with a little iodoform. Again, a sample of decomposing pus, which had fatal effects when introduced unmixed into the peritoneum of the mouse, had no influence whatever upon the health of the animal if treated with iodoform, which meanwhile left intact the pyogenic microbes. In the absence of their toxic products, the bacteria could do little harm, and would probably soon be disposed of by phagocytosis.

We seem thus able to understand how iodoform dusted over the cut surfaces of a wound may have great antiseptic efficacy, more especially as it remains for a long time unconsumed among the tissues, and is remarkably free from irritating properties. In circumstances where it is impossible to exclude septic agencies, as in operations upon the mouth or the rectum, or when putrid sinuses are present, iodoform is of very high value. Before applying the iodoform in such cases we mop the cut surface with a solution of chloride of zinc, forty grains to the ounce of water, which has a remarkable power of retarding septic changes in wounds in the presence of contaminating materials. On the field of battle iodo-

form is probably the best means at present at our disposal. Again, in compound fractures, while we endeavor to purify the wound with strong carbolic lotion, we cannot be certain of entire success in this respect, and I should be sorry to dispense with iodoform.

But if you operate when the integument is unbroken, with a sufficient space around for the application of a dressing, I would not recommend you to use it. To apply it to the interior of the wound would be then entirely superfluous, provided that you have taken care to avoid its contamination while operating, and have at your disposal some trustworthy material for preventing the subsequent access of septic mischief. This, as we have seen, iodoform cannot be expected to do. A porous material impregnated with it, when soaked through and through with blood or serum, will allow the microbes of external defilement to propagate in its substance, though doubtless more slowly than if the iodoform were absent. It is essentially in the interior of the wound that the virtues of iodoform are displayed; and the original Vienna practice of dusting the cut surface with the powder, and applying simple absorbent cotton externally, gave results which were much extolled at the time, and were probably not far inferior to those obtained by the use of iodoform wool or iodoform gauze. An iodoform dressing affords no security against the penetration of septic microbes to the outlet of the wound. At the same time, it is easy to see that circumstances may often arise in which iodoform dusted over the cut surfaces may fail to act effectually; as, for example, when those surfaces are separated by extravasated blood.

THE NATURE OF FISH POISON.

Some persons exhibit an idiosyncrasy to being poisoned by fish, while to others no harm seems to happen under any circumstances. Arnstamoff has observed eleven cases of poisoning in human beings after eating salted salmon; of these, five died. An examination of the fish showed a peculiar soft consistency, but no putrefaction. A large number of living micro-organisms were seen under the microscope, and these bore a strong resemblance to typhoid bacilli. Symptoms of poisoning developed in the patients in ten to twenty-eight hours after ingestion of the fish, but the amount ingested had no influence on the rapidity and intensity of the toxic symptoms. Complaint was made by the patients of general weakness, abdominal pains, dyspnœa, mydriasis, diplopia, vertigo, dryness in the mouth, dysphagia, constipation, and a lowered temperature. The post-mortem signs in the fatal cases were very indefinite, and if anything only pointed to death from asphyxia. Bacteriological and microscopical examination of the various organs afterwards revealed the presence of the same microbes which had been detected in the fish. Pure cultures made with theses microbes were injected into nineteen rabbits, two dogs and two cats. The latter four animals recovered, but only after severe illnesses, while all the rabbits succumbed. Both in the symptoms presented during life, and in the presence of the microbes in the organs after death, the toxic effects observed in the animals were identical to those noticed in the patients above referred to.—*Food*, February, 1893.

THREE THINGS THAT BALTIMORE NEEDS.

In an address delivered February 27th (Baltimore *Sun*) before the Charity Organization Society of this city, Dr. John S. Billings, of Washington, spoke, in part, as follows: The importance of accurate statistics regarding the health of the city Dr. Billings called attention to, and declared that one of the first sanitary needs is a system of statistics which will give accurate death rates for different

parts of the place, for different classes of population and for different diseases. To collect such statistics would cost money, but the results would more than compensate for the expenditure.

A second urgent sanitary need in Baltimore is a system of sewerage to remove the water fouled by domestic use. No matter how the excreta are to be dealt with, a system of sewers is needed to carry off slop-water, laundry wastes and bath wastes. Until this is provided the fullest and best use of the city's fine water supply cannot be made. The laboring poor will use the least possible quantity of water in their homes if they are compelled to carry it out after it has been used. It would be folly, however, not to use the fouled water to carry off the excreta, since this would involve little extra cost. Baltimore needs to get rid of her 60,000 privy-vaults, boxes and cesspools, to stop storing up filth in pits, in cellars and yards; to put an end to the constant pollution of the soil which is going on all over the place, and the consequent pollution of the air and the subsoil water, which is so apparent in many parts of the city in hot weather.

The statistics of all cities show that the general death rate falls after the sewering of a city. This is not due wholly to the removal of sewerage, but to the soil drainage, which necessarily follows sewers, even if the sewers are watertight.

There are parts of Baltimore which need this drainage badly to secure dry cellars, which are so important for the health of those who live over them. In discussing objections that may be offered to a plan of sewering the city, Dr. Billings said that the consideration of vested interests and the fear of taxation might form obstacles that would prevent any general sewering, at least until a great epidemic comes. Continuing, he said:

Perhaps the epidemic may not come, but I think it will. Like causes under like circumstances produce like effects, and the history of other cities gives decisive proof of the different effects produced by epidemic forms of disease in sewered and unsewered cities. I do not think it will be cholera that will insure the change, although that is possible. It seems more probable that yellow fever will be the agent that will force the matter upon public attention, and under certain conditions of temperature the results will be disastrous—more so than they were in previous outbreaks here. It is a long while, sometimes, before the spark and the powder come together, but we do not allow the storage of powder within the city limits.

Dr. Billings suggested that a separate system of sewerage, one into which the street washing does not pass, is what is wanted in Baltimore. The cost, he said, would be small as compared with the benefits to be derived, while the construction of good sewers would increase the value of real estate from ten to twenty-five per cent.

A third sanitary need, Dr. Billings said, is to have the city control the headwaters of the streams from which it draws its water supply in order to insure that these waters shall not be polluted. Better pavements to prevent soil pollution by soaking from the street, as well as to lessen noise and vibration, are also needed.

HYDATIDS OF THE BRAIN.

At the third session of the Medical Congress of Australia, held in Sidney, Australia (*Brit. Med. Jour.*) Dr. Verco read a suggestive paper on the Treatment of Hydatids of the Brain. He proved that one-third of all cases of hydatids of the brain communicated with the lateral ventricles, and as a result a large percentage

of the fatal cases was due to draining the cerebro-spinal fluid, and leaving the ventricles dry. To obviate this, he suggested that in future, after emptying the cyst through a trephine hole, and washing out as usual, no drainage tube should be left, and that the flap should be closely stitched, and thus the cavity left hermetically sealed.

Dr. James Graham, of Sydney, showed a patient, a powerful, active young man, from whom, two years earlier, he had removed a hydatid of the brain 4 inches in diameter, and containing 19 ounces of fluid. Owing to optic atrophy, the patient's vision was diminished to perception of light, but he was able to earn his living as a basket maker.

THE KEELEY CURE.

We clip from the *Medical News* an article published by Dr. Chapman in the *Chicago Medical Recorder* of February. Dr. Chapman states that for the purpose of investigating the "cure" he obtained a position in one of the Keeley Sanitariums and carefully studied out the subject. His views as to the nature of the remedies, gained from personal experience in about three hundred cases, both in and out of the aforesaid sanitarium, are as follows:

The formulary of the gold treatment is almost, if not quite, the same in all of these institutes.

No. 1. Tonic. Known in the institutes as the "dope:"

℞.—Aurii et sodii chlorid. . . . . gr. xij.
Strychninæ nitr. . . . . gr. j.
Atropinæ sulph. . . . . gr. ¼.
Ammonii muriat. . . . . gr. vj.
Aloin. . . . . gr. j.
Hydrastinin. . . . . gr. ij.
Glycerini. . . . . ℥j.
Ext. fl. cinchon. comp. . . . . ℥iij.
Ext. fl. coca erythrox. . . . . ℥j.
Aquæ dest. . . . . ℥j.—M.

S.—I dram at 7, 9, 11 A. M., at 1, 3, 5, 7, 9 P. M.

No. 2. The injection known in the institutes as the "shot."

℞.—Strychninæ nitr. . . . . gr. $9\frac{1}{10}$
Aquæ dest. . . . . ad ℥iv.
Potass. permangan. q. s. to color. . . —M.

S.—Begin with gtt. 5, which equal gr. $\frac{1}{10}$, increase one drop at each injection until the physiologic effect is produced. Four hypodermatic injections to be given daily, beginning at 8 A. M, then at 12 M., 4 P. M., and 8 P. M.

No. 3. Used with No. 2:

℞.—Aurii et sodii chlorid. . . . . gr. $2\frac{1}{2}$.
Aquæ dest. . . . . ad ℥j.—M.

S.—Gtt. 3, every four hours, in combination with the strychnine solution, for the first four days.

This last prescription is used only for the moral effect, which is produced in the following manner: Five drops of the strychnine solution are drawn into the syringe, and then three drops of the gold solution are drawn in and mixed. This produces a golden-yellow color, to which attention is called, and the patient is further assured as to the reality of the presence of the gold by the stain left on the skin after the hypodermatic needle has been removed.

A positive disgust is in almost, if not in every instance, produced in the fol-

lowing manner: The patient is given a drink of whiskey, then the so-called bichlorid of gold solution, really a solution of strychnine, is injected in his arm, but at the same time, and without his knowledge, he receives one-tenth grain of apomorphine. It takes but a comparatively short time for the emetic to produce its effects; more or less violent emesis is produced, and the patient soon associating the in-taking of the whiskey with the subsequent disagreeable and sickening vomiting, acquires a positive disgust for the liquor, and is not able to keep any on his stomach. Now he acknowledges the wonderful power of the hypothetical gold compound, and surrenders unconditionally. He is converted, and from an unbelieving scoffer is changed into a disciple and supporter of the prophet. These are the cases that are the most widely advertised, and that have done the most good for the "Keeley Institute."

It will be observed that the foregoing method is nearly the same as that quoted by us in the JOURNAL of February 25th. This similarity in the testimony received from different observers inclines us to believe that both the principles on which the cure is based and the therapeutic agents used now are now known to the profession.

THE PATHOLOGY OF LAZINESS.

The editor of *Food* writes: We fear that many persons are unjustly compelled to bear the reproach of laziness, when their indisposition to exertion really has a physical basis, and depends upon some grave disturbance of nutrition. Such cases deserve our sympathy, instead of the contempt which is unsparingly meted out to them by their more robust associates. Women, whose instincts are often remarkably correct, understand this, and when a child is unusually quiet and prefers to sit still, instead of joining its companions in play, the mother's fears are aroused; she thinks at once that something is wrong, and that the child is going to be sick, or is actually suffering from some obscure internal disorder, possibly hip-joint or spinal disease. This explanation may apply in adults as well as in children. Some years ago, a clergyman, who had been very active in church work, was noticed to gradually give up one duty after another, and to show marked disinclination to perform any work requiring much exertion of body or mind. He was generally thought to be losing his interest and getting indolent. Indeed, he feared, himself, that this was the case, and it gave him much mental distress and spiritual disquietude. He afterwards came under the observation of a physician, who found that he was a sufferer from Bright's disease, from which he subsequently died. He was especially regretted by those who had hastily and ignorantly condemned him for what was assumed to be a fault, but which, in reality, was due to grave disturbance of nutrition from the approaches of an insidious organic disease. Victims of chronic malarial poisoning afford typical illustrations of laziness, although clearly suffering with bodily disorder. Who can estimate the amount of physical disability and apparent indolence which is directly due to dyspepsia and chronic indigestion? Rheumatism and the muscular pains of lithæmia, locomotor ataxia and its nerve-counterfeits, incipient brain disease and arterial degeneration, are all potent factors in producing indolent habits of body, while phthisis, pernicious anæmia and neurasthenia have physical weakness as a prominent and early symptom. A dislike for study in a child may often be traced to errors of refraction which are remediable by properly adjusted lenses.

Before pronouncing, therefore, a verdict of moral fault, and condemning those who are conspicuously deficient in energy, and whose powers of work are notably below the average, it would be well to stop and inquire whether they are not lab-

oring under physical disability instead of indolence. In such cases it may be found that better results will be obtained by placing them under the charge of a physician than under an instructor in morals. The decision between the hospital and the work-house is often a difficult one to make for those wrecks of humanity, the physical degenerates, who become tramps because they have a moral and physical aversion to work. In a strictly analogous manner, in higher walks of life, when a physician prescribes physical exercise for patients who obviously require it, he often finds his instructions disobeyed simply because the physical disability of the patient is the real reason for his condition; for if he had the power to follow the prescription he would not need the advice. It appears, indeed, that, in certain instances, laziness may be a conservative effort of nature; and, as a symptom, will be estimated at its proper value by the intelligent physician.

A GOOD MOVE.

We are informed by an exchange that the medical students at the Edinburgh Royal Infirmary are instructed in sick-room and convalescent cookery. The demonstrations are given in the large theatre of the Infirmary in January and February, by teachers from the Edinburgh School of Cookery. Tickets for the course cost only 3s. 6d., and it is to be hoped that a large number of students will avail themselves of this opportunity to gain practical information on matters of such vital importance to their future patients. The main heads of the programme are: Beef tea, beef essence, savory custard, mutton chop in paste, blancmange, omelette, lemonade, restorative soup, steamed fillets of sole, stewed sweetbreads, calf's foot jelly, gruel, egg drinks, white wine whey, mutton broth, minced chicken, cauliflower, apple charlotte, fish soufflée, barley water, linseed tea, peptonised foods, tea, coffee and chocolate.

THE MECHANISM OF BREAST-NURSING.

The best nourishment for the infant is that drawn from its mother's breast. In order to do this it makes suction upon the nipple, of which we will briefly indicate the mechanism.

The infant hermetically encloses the nipple by seizing it on one side with the lip and the upper maxilla, and with the tongue and lower lip on the other; the veil of the palate being down and closing the mouth at the back. Aspiration is now produced in this cavity by a movement of the tongue and of the inferior maxilla, which by being drawn backward, create a vacuum, and the cheeks at this time can be seen to be drawn inward on each side between the alveolar arches. The milk then flows into the mouth, the cheeks again swell outward and the infant swallows; and on performing the movement of deglutition, a sound is heard as the liquid passes from the mouth into the pharynx and œsophagus.—Prof. Tarnier, in February number of *Food*.

Recommendations of Therapeutic Agents.

Lupus of Face; Cure by Tuberculin. By J. William White, M. D., Assistant of the late Dr. Agnew, of Philadelphia.—Mr. J. W., of Titusville, aged fifty-nine years in 1890, had been under treatment for two and a half years for an ulcer of the face, occupying the left cheek, the parotid region, and the side of the neck, and measuring on an average about four inches in diameter. It began on the face in front of the upper portion of the ear as a small scab, which steadily extended, and under which ulceration developed.

The diagnosis by the various surgeons whom he had consulted, and who

treated him, had been epithelioma. He had been in the hands of four men of experience, some of them of excellent position in the profession. He had had eight cutting operations performed, besides numerous plasters and other local applications.

At the time he came under my care I was using the newly discovered Koch's lymph, now known as tuberculin, or paratoloid. He remained in Philadelphia three weeks, during which time he received in the lumbar region six injections of this material, beginning with 0.1 milligramme, and increasing in strength up to 0.5 milligramme each. A distinct local reaction (at the side of the sore) occurred after each injection, diminishing in intensity with the later ones; no local treatment was employed. At the end of three weeks healing had so far progressed that it was thought proper to let him go home, and ten days later the ulcer was entirely healed. He now, twenty-three months later, presents a sound and permanent scar. There has never been the slightest solution of continuity since that time.

This case is of more than usual interest on account of the length of time which has now elapsed since cicatrization occurred. As yet but few permanent cures by the use of paratoloid have been reported. Cheyne, by a system of continuous and increasing dosage, has obtained rapid healing in a number of cases, which remained in good condition for some weeks. In this patient the previous failure of a number of operative procedures, and a great variety of local applications, and the prompt, satisfactory, and apparently permanent healing which followed the use of tuberculin, all local treatment being withdrawn, strongly emphasize the unique properties of that remedy. It would seem that even if success from its use is only occasional, it may occur in such desperate and otherwise hopeless cases that it is worth more frequent trial than the profession, in the reaction from its too extravagant anticipations, is now giving it. Schulze-Berge & Koechl are agents in this country for Paratoloid.

Medical Items.

It is reported that there has been much cerebro-spinal meningitis in St. Louis, this winter.

How to disinfect after a scarlatina visit.—Put your hand in your pockets, and walk round the square, and don't tell anybody. This prescription is from a high authority.

The New York Board of Health has ordered that after April 1, 1893, each lodging-house shall provide a room for isolating lodgers suspected of suffering from some contagious disease. The bed in this room must be equipped with a wire mattress.—*Memphis Medical Monthly.*

The Medical Society of North Carolina will meet in Raleigh this year instead of Winston, the change in place being necessary on account of the burning of the hotel in Winston. The date of meeting is May 9.—*Ex.*

Little Sister—"Mamma says Mr. Nexdoor is sufferin' from a complication of diseases." Little Brother—"I guess that's so; I've seen three different doctors go in there this morning."—*Good News.*

The vote against the establishment of an Infectious Hospital for Baltimore is being reconsidered by our City Council, and committees have been appointed to make an estimate of the cost of the site for it.

Dr. Roberts Bartholow, of Philadelphia, has regained his health and resumed his practice, to the delight of his many friends and admirers throughout this country.—*Ex.*

The best record of systematic beneficence that could possibly be obtained is contained in the day-books of physicians. Charity is more familiar to physicians than is remuneration.—*Ex.*

The Woman's Medical College of Pennsylvania now requires all new matriculates to take four annual courses of graded instruction before being eligible for graduation. This is an evidence of the rapid progress made by the movement to elevate the standard of medical education.—*Ex.*

Dr. J. Pembroke Thom, president of the Home for the Feeble-Minded, near Owing's Mills, Baltimore County, Md., has been endeavoring to arouse interest in the proposed home for epileptics in Maryland. Since the last meeting of the Legislature Dr. Thom has received many applications from friends of epileptics for their admission to the Home for the Feeble-Minded. Several epileptics have been admitted to the Home, and afterward it was found necessary to remove them on account of the injurious influence they produced on the feeble-minded. —*Sun.*

A Hungarian family of five brothers and four sisters living in this city presents a remarkable case of longevity in ancestry. Their grandparents were all centenarians, the paternal grandfather having passed the age of one hundred, the paternal grandmother also being over one hundred, the maternal grandfather having lived to the age of 103, and the maternal grandmother to the age of 114. In the curiosities of medical experience in examinations for life insurance we doubt whether a more remarkable instance of centenarianism has ever occurred. —*Baltimore Underwriter.*

The Sanitary Board of Savannah, Ga., has an eye to the welfare of the people of that city. It has decided to demand from the city authorities a strict enforcement of the "soil-upturning" ordinance between May and November 1, in order to insure to the citizens the fullest measure of protection during the heated term. It was the sense of the board that all the street railroads be notified to make their contemplated improvements before May 1, as after that time they will not be allowed, under any circumstances, to turn up the soil until November 1. Neither will the street and lane department be allowed to do anything during the same period in the nature of paving or laying street crossings.—*Sun.*

Taking Hold of the Liquor Trade.—The people of Clark County, Ga., believing that large profits could be made from the liquor traffic, got authority to take that traffic into their own hands. They did not want the right to impose high licenses, which would only have for result the sale of inferior liquor. They wanted to have good liquor dispensed and to regulate the traffic. Adopting this view of the matter, they appointed commissioners to decide upon the places where liquor should be sold, chose their own bar-keepers and laid down rules and regulations by which they were to be guided, under pain of dismissal for violation. The annual report made by the county bar-room commissioners shows that from a money point of view the plan has worked well. There was bought during the year $55,000 worth of liquor, from which was realized $77,000, with $5,000 worth of stock on hand. "The tax-payers," we are told, "are now chuckling over their thriftiness."—*Sun.*

The chief part of the exhibit which Johns Hopkins University will make at Chicago the coming summer was seen displayed in the university library. It consists of two sets of one hundred volumes each, including the principal publications of the Johns Hopkins press and important books by members of the faculty. The books are handsomely bound in levant and red, green and brown morocco. The book-making was done in Baltimore. Complete sets of the various scientific journals are included in the exhibit. The books will be arranged in duplicate upon a bookcase having shelves on both sides, in order to make them accessible to a larger number of visitors. The university will also exhibit a number of framed title pages and fac-similes of important publications and a series of photographs of the university buildings.—*Sun.*

The Academy of Science of this city took possession last week of its new home, N. E. corner of Cathedral and Franklin Sts. The building is the gift of Mr. Enoch Pratt, and is furnished by the Academy. The first regular meeting in the new building was held March 6. Dr. Philip R. Uhler presided, with Edward Stabler, Jr., recording secretary. Mr. William H. Fisher was elected treasurer. A large number of corporate and active members were elected. A circular letter called attention to Mr. Enoch Pratt's purchase and presentation of the new building and to legacies being left to the institution by the late A. S. Abell and Professor Edward G. Lehmann, which were used in the purchase of the late home of the Academy, 12 E. Centre St. The Centre Street property is to be sold and the proceeds are to be applied to alterations and repairs of the new building. The following were elected life members: Ernest Knabe, William Painter, Andrew Reid, German H. Hunt, Daniel Miller, Edgar G. Miller, Douglas H. Gordon, George W. Gail, Wm. T. Walters, J. Henry Stickney, Wm. P. Clotworthy, Richard C. Magill, Joshua Levering, Philip T. George, George Gildersleeve and Robert Garrett. Dr. E. A. Andrews, of Johns Hopkins University, lectured on "Notes of a Visit to Bemini, One of the Bahamas."—*Sun.*

Dr. Julian J. Chisolm, Surgeon in Chief to the Presbyterian Eye, Ear and Throat Charity Hospital, reports an increase every year in the steady growth of this charity work. For the year 1892, the attendance was 29,388, or 107 patients for each day of the year. The individuals numbered 9,736, of which 7,295 were eye cases, 1,374 were ear diseases, and 1,067 were affections of the throat. 8,487 were whites, and 1,249 were colored patients. During the year 1,864 operations were performed, of which 170 were for cataract; there were 100 tenotomies for squinting eyes, 37 lost eyes were extirpated; there were 331 operations on the lids. The finances of the Institution exhibit the wholesome condition of having a balance in the treasury at the end of the year. A subject of much interest in the report is the method of relieving the Free Dispensary of improper applicants for treatment. The Hospital employs an "inspector" who examines into the financial condition of all persons found in the reception room. Those who are accustomed to pay their family physician for medical services are sent away, and are advised to consult any member of the hospital staff at their respective offices. During the past year, several hundred applicants for free treatment were sent away from the hospital. Notwithstanding this wholesale dismissal, the number of persons treated nearly reached 10,000. This very large attendance places the Presbyterian Eye, Ear and Throat Charity Hospital among the largest special hospitals, in the United States.

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THE NECESSITY OF HAVING MEDICAL DIRECTORS FOR OUR PUBLIC SCHOOLS.

BY KATE CAMPBELL HURD, M. D., OF BALTIMORE.

The health of school children is one of the most important subjects that can claim the attention of public-spirited men and women, and especially of school boards, who know, theoretically of course, that the best mental and moral development of school children of to-day is necessary to produce the most favorable law-making and law-abiding citizens of to-morrow.

If this is true, we should have for our girls and boys not only the best physical, mental and moral teachers, but supervisors who have had thorough medical and physical educations.

In this country, the average medical graduate is a conceited, self-appointed censor of civilization. The magic title, M. D., does not suddenly transform the inexperienced youth into a capable physician, nor into a man worthy of being entrusted with the badge of medical supervisor of schools.

The average teacher of gymnastics is, to say the least, somewhat prejudiced in her enthusiasm as to the good to be derived from one exclusive set of exercises; she sees in each human being a lack of poise or of health which she thinks her system alone can give.

To her the world-wide panacea is "gymnastics." She lacks the balance which a little medical education would give her, and which would enable her to adapt special exercises to the varying conditions of health and strength of her pupils.

Education implies a development in all directions, neither mental nor physical alone. But how can there be perfect growth in unhygienic surroundings, and why are our school-houses and homes so poorly adapted to carry out the rules of health ?

One answer is found in the fact that there are very few colleges in this country where there are laboratories for carrying on investigations in bacteriology and hygiene. No one will deny that there has been great need of such laboratories, and that if medical directors are necessary for schools, they must be given practical lessons in house sanitation, in plumbing, heating, ventilating, building and furnishing in general, in order that they may advise architects and plumbers in the erection or re-modeling of school-houses and dwellings.

On the subject of school hygiene, Dr. Stanley Hall* says: "Nature inclines the normal child to free and almost incessant activity; the modern school requires him to sit still. His instincts need sunlight; but the school-room is often too dark; while the first steps in reading and writing require for the child nearly as abundant sunlight as does microscopy for adults. . . . The energies of the hand are all focussed on the wagging pen, which is too small, too light, too exact and monotonous in its movement for the stage of development of the higher centres. . . . The school-house economizes in either its ventilating system or its working, or both, and rarely exterminates the school smell. . . . The seat in which so much time is spent does much to determine the attitude during the most critical years of growth. It should be fitted to each child like a suit of clothes, and changed at least semi-annually. . . . Both the tax-payers and the teachers are suspicious of the doctor in schools, and rarely favor medical inspection, while doctrinaries are permitted to establish the recess in many entire cities, to prescribe positively deforming attitudes in writing, and to enforce systems of gymnastics that are unnatural and do more harm than good. . . . Most of the muscular system, which is the organ of the will and has done all man's work in the world, is allowed to grow flabby, and thus the chasm between knowing and doing is widened, the will is weakened, and it is forgotten how akin weakness is to wickedness, or how nearly morality depends on physical perfectness."

The result of all these dangers is seen in the loss of weight on entering school, and the growth of diseases of eye, spine, stomach, throat and nerves.

Let us look into the question of the headaches and eye-strain among school children. It can not be doubted that one cause of the eye-strain in school children is poor ventilation. The excess of CO_2 in air causes an overfilling of the blood vessels of the head, the face looks flushed, and the delicate capillaries of the eyes are so dilated as to prevent proper action of the muscles of accommodation.

*"Pedagogical Seminary," June, 1892.

Again, there is the common lack of adjustment of desk and seat to the child who is to occupy it. She should not have to bend her body into a bow to read her books, and sit on the edge of her chair to write. The seat should be of such a height that the child's feet could rest comfortably on the floor, or preferably on an inclined foot-rest. The desk should be just the height of the elbows when the pupil is seated.

Poor lighting is perhaps the most frequent cause of eye trouble and headache. The light should come from windows at the back and left side of the room—preferably from the north. Light from overhead, directly from the back, and from the right, casts its heavy shadows across the page. Reflected light from windows at the front of the room is most injurious, and is at the same time a very common way of lighting public schools.

Then again, many school books are printed with pale ink in small type, and are responsible for difficulties of vision and headaches. Is it to be wondered at that seventy per cent. of those who are beginning manhood, or womanhood, are near-sighted? In village schools where the air and surroundings are better, the terms shorter, and where the chidren live a long distance from the school-house, only 1.4 per cent. have myopia, while 21 per cent. of their city cousins are obliged to wear near-sighted glasses. About one half of these girls and boys inherit some defect of vision. The negroes, whose ancestors have had no fine print to pore over, have very little myopia. Only $2\frac{1}{2}$ per cent. of native negroes are near-sighted, though some have lost one or both eyes through carelessness.

The question of ventilation, *per se*, has been the subject of long discussion. It is granted that every pupil should have 300 cubic feet of constantly changing air, whereas most school-rooms are thought to be well ventilated if each child has 120 cubic feet. This scanty allowance of air soon becomes contaminated with dust, organic and inorganic, from the shoes, starch granules from the dresses, exfoliate of the cuticle, excreta of the respiratory passages, water, CO_2, moisture &c.,—all easy to be discovered—besides millions of bacteria and spores of minute microscopic plants, waiting for fields on which to propagate and establish colonies.

It is not necessary in this paper to describe the best methods of ventilation, but it is most important that every medical director should understand them, and should know how to test the purity of the air of rooms.

In building a school-house, particular attention should be given the details; for instance, the walls of the room should be perfectly smooth and washable. There should be no angles at the junction of walls with floor or ceiling. There should be no cracks in the floor for dust to lodge in. The flight of stairs should be broken at every sixth step for a resting place, and to make the ascent easy, the steps should be wide and low.

Questions of playground and of recess are essential subjects for the attention of the medical director. The relation of the child to her work and rest, causes of inattention, of failure in examinations, &c., are worth careful investigation,

but they demand for the medical examiner an education in physiological psychology.

The man or woman who is to be a medical director of schools should have a university education which should include a careful study of pedagogics and psychology, as well as a medical training comprehending practical work in the special branches of bacteriology and hygiene, ophthalmology and orthopædics, besides physical culture and medical gymnastics. Even this course should be supplemented by a few years' general practice before one is competent to assume the responsibility of prescribing to the physical necessities of growing children.

One of the first duties of the medical director is to make examinations of the pupils in the school. The condition of this body as a whole should be noted, its symmetry and suppleness, the muscular tone, the nervous irritability, the smoothness of the skin. Heart and lungs should be carefully sounded, and eye-sight and hearing tested. Questions as to sleep and eating, pain and disease, past accident and family history are of great value as indicating causes for deformities and weakness.

Measurements with tape and rods are of very little value so far as any single child is concerned. Children are so sensitive to external conditions that weight, height, lung power, size of biceps, strength of hands and of back vary from hour to hour.

In a growing child it is very difficult to say what physical improvement is due to exercise and what to natural laws. Tests of strength may interest and induce the child to make his best efforts in one or two directions; they are useful only in so far as this stimulus can be used for the general, and not merely special, improvement. The chief value of measurements to the physician is in their relation to mental and physical perfectness.

Psychological tests should be made of greater value than physical tests; until we have a national physical laboratory to determine exact measurements for strength tests, and more scientific and accurately marked dynamometers, school offices should be equipped with some of the *psychological* apparatus of our university laboratories.

The mind depends upon the general nervous system for strength, and more especially upon the sympathetic system, which in its turn depends upon the digestive and circulatory systems. The condition of the circulatory system depends upon the tone of the muscular system, which in its turn depends upon the motor nerve system.

With all these general conditions to watch and regulate, the special work of the medical director will be centered on the students who are below the average in development.

A well-trained gymnastic teacher should take the strong average members of the class and give them the Swedish drill, or whatever exercises she chooses; but to the treatment of deformities or to any case of peculiar weakness of heart or

lungs, the physician should give personal care and attention. This work will probably lie in the line of orthopædics. Deformities must be noticed and treated in their first stages.

The early symptoms of Pott's disease are the square shoulders, the projecting abdomen, the stiffness in reclining, the peculiar stoop which keeps the back motionless, the backache, growing pains, stomachache and general disinclination to run or play.

The mother rarely notices these points, or thinks that the child stands badly from habit, until there is a small "hump" in the back and the characteristic "pigeon breast."

In this stage the most careful mechanical treatment under the most favorable conditions is necessary to cause a recession of the deformity, if indeed a perfect cure is possible.

More boys than girls have Pott's disease. It most frequently comes on between the first and fifth years. The prime cause is always the *tubercle bacillus*, inherited from one or other phthisical ancestor. Owing to the erect posture of the spine, a jar or the superincumbent pressure after some slight injury to the lining membrane of the spinal canal, determines the location of the caries.

The old-fashioned methods of treatment by corsets and braces only aggravate the deformity when it is in a progressive state, and gives very little relief except after the deformity is fixed beyond amelioration. Surgery is of no use unless the pressure of the mal-posed bones upon the spinal cord is causing paralysis. Even then an operation does not always cure the paralysis, besides being difficult to perform and weakening the vertebræ still more. Recumbency alone will not cure Pott's disease, because, while giving the spinal column a relief from pressure, the spinal muscles become weaker. A proper combination of these methods of treatment by exercise, rest, stretching and corsets might save many a school child years of suffering and deformity.

Lateral curvatures of the spine are more common between the eighth and fifteenth years of life, the period of the child's greatest growth, and the time when most care should be taken by the school physician. The symptoms here, as in Pott's disease, are very slight at first. There is no pain and no subjective symptoms, but a slight elevation of one shoulder, a projection of one shoulder blade, a prominence of one hip, and a tendency to stand and sit badly. Schools are greatly to blame for this disease. The pupils are taught to sit with their bodies twisted, or are obliged to be cramped in their seats for hours every day. The muscles of one side of the body are over-stretched and weakened; there is the downward pressure upon the twisted spinal column, which causes the bones to rotate and then bend, the bodies of the vertebræ grow in the direction of the least resistance and thus alter the diameters of the thorax.

Lateral curvatures, however, have a tendency to cure themselves. Take away the cause and the muscles regain their tone before the deformity has become fixed, provided it has been noticed in a very early stage, and proper exercises have been

taken to strengthen weak muscles. If schools could be provided with one of Dr. Zander's measuring machines, so that the medical director might note a curve when the child enters the school, and if the desks and chairs in the study hall and recitation rooms could be arranged properly, and if the teachers could be taught the proper positions for pupils in writing and studying, a great step would be taken towards securing erect and symmetrical bodies for the growing children.

In the school gymnasium should be found machines for the correction of all deformities. Those machines invented by Dr. Gustaf Zander, in Stockholm, are decidedly the best kind, but they are very expensive. They are made of fine steel, their intricate mechanisms are accurately adjusted, the seats are upholstered and the tariff on them is enormous. But the results obtained with these machines in the cure of deformities, &c., at the Woman's College, Baltimore, and at the Bryn Mawr School, as well as at the Zander Institute in New York, and at the various sanitariums and orthopædic institutes of Europe, testify that economy consists in buying the best things. The results of treatment in these machines are much better than by any other treatment.

Institutes and schools which cannot afford Zander machines, but which have a scientific orthopædist in charge, use cheaper machines made of wood, with weights and pulleys instead of physiological levers; they employ masseurs in place of the Zander machines, which were invented to do away with inaccurate human pressure, &c.

In addition to treatment by machines, by posture, by pressure and by assisted exercise, there are gymnastic exercises belonging to the domain of medical gymnastics which must be used in the treatment of deformities. After these exercises some cases require bandages in school as a reminder of the high shoulder and its postural treatment. An inclined seat or a wedge may be used under the child's low hips for a short time during the study hours every day, but this can be so easily over-used, that the physician must watch the progress of the disease with special care. Corsets are always a last resort; their fitting demands an exactness which no manufacturer knows enough to give.

As I shall show by statistics, there are few cases of absolute deformity in a school, in comparison with the cases of incipient curves which may or may not cure themselves; of round shoulders, which may or may not go on to deformity, and of other irregularities of bones and joints which come within the special province of the orthopædist, and which can be readily cured by gymnastics, swimming, baths and apparatus provided for the purpose.

It is not the place here to urge the building and furnishing of gymnasiums, swimming pools, shower-baths and play grounds for our schools—I merely wish to show from statistical tables compiled abroad and at home, the conditions of school children as regards physical perfection, and to urge the necessity of having medical directors, appointed by the city, with good salaries, for the care of the school children; and to call to your attention the lack of adequate fitting schools in the medical colleges of America for such directors.

Where is there a medical school in which the principles of mechanico-therapeutics are taught? The universities have gymnasiums which are devoted to athletic training and to contests of strength of one set of muscles, and possibly to a little theoretical work; but no medical school has a place for the practical demonstration of the treatment of orthopædics by massage, machines or medical gymnastics.

Students are taught physiology, pathology, bacteriology, but the practical importance of mechanico-therapeutics is everywhere practically ignored. Is this branch not as important as any of the others?

Let us look at the statistics of the health of school children, if there is any doubt as to the answer of this question. In the schools of Scandinavia, fifty thousand school children were examined by physicians appointed by the government. Nine thousand of these were abnormal in some respect. Some were deformed, others were nervous, others had chorea or epilepsy, while many others had almost constant headache. Drachman, in Denmark, examined children with regard to lateral curvatures of the spine and found decided deformity in 1⅓ per cent.

Of 3,000 cases treated at the London Orthopædic Hospital, 937 had spinal deformity, and ⅓ of these, or 10 per cent. of all, had lateral curvature.

Dr. Bradford, of Boston, thinks that spinal deformities are much less common in American children, though more girls are deformed than boys.

Through the kindness of Mr. Wise, the Superintendent of Education of Baltimore, I have visited several public schools, and have obtained the following statistics from about two thousand girls, of ten to eighteen years of age. Two hundred grammar school children from the poorest classes of the city, who were crowded into a very old and most unhygienic school building, furnished the following report: Twenty-two either wore glasses or touched their books with their noses and had red eyes. Forty of the larger girls were round shouldered with left shoulder higher than right. Fifty-two smaller girls had left shoulder higher than right. Forty others had right shoulder and left hip high. This leaves only fifty-eight who stood evenly and who had no apparent defect of vision. These children were all obliged to sit in "No. 2 position," in writing, *i. e.*, right shoulder forward, right elbow on desk; body twisted. The desks were low and the seats uncomfortable and old-fashioned. The light in the class-rooms was invariably poor, either glaring from windows at the front, or falling directly over the back, or coming mainly from adjoining rooms through glass partitions. Ventilation was from windows.

At another grammar school in a better part of the city where there were five hundred pupils in a more modern building, the girls of the upper classes, who seemed to come from well-to-do families, were not as a rule round shouldered, but they stood invariably with left shoulder higher than the right. They, too, sat in "No. 2 position" to write. They inclined their heads to the left shoulder, and raised that shoulder to regulate the balance. Owing to this position the left thigh is more supported than the right, making the left hip higher and adding to the

liability of permanent spinal curvative. Every public school girl seemed to increase this tendency to left-sided prominence, by carrying five or six books on the left arm to and from school. Five per cent. of the pupils in the school had some weakness of the eyes. The poorer and younger children of the school were all round shouldered, and flat chested, with prominent abdomens. Here, as before, the rooms were crowded and the ventilation and light were arranged for economy of money and space, though the seats and desks were more suitable.

In another grammar school in an old building, twice as many girls were crowded into the rooms as the desks should have accommodated The seats were ill-suited to their occupants, and out of the five hundred pupils, four had marked scoliosis; morever, as they stood squarely on the floor with arms down and heads erect, there were scarcely twenty exceptions to the rule of left shoulder high.

One of the Female High Schools gave the following figures: Three hundred pupils present; 10 per cent. wore glasses or were near-sighted, 45 per cent. had left shoulder high, 5 per cent. had right shoulder high, 20 per cent. were round shouldered. One hundred children from 8 to 13 years old gave the following figures: 12 were undersize, 4 were anæmic or consumptive, 12 had extremely round shoulders, so stiff that they could not be put into position, 8 held left shoulder higher than right, 6 held the right shoulder higher than the left, and had the left hip higher than the right.

In January, 1892, I measured two hundred girls of 18 to 30 years of age who worked in the factories and stores of Baltimore. Two-thirds of these were round-shouldered and flat chested. Fifteen had hæmic or organic heart murmurs. Forty-two had weak eyes. Twenty-three suffered continually from headache and backache. Fourteen had chronic catarrh. These women were given twenty lessons in gymnastics at the Bryn Mawr School, and were re-measured. Their chest-girths had increased from two to four inches; with but few exceptions they stood erect, while their general health and thair mental and moral improvement was noticeable after the first half of the course.

Now let us turn to girls of a different class of society. Out of one hundred and thirty new students at Woman's College, Baltimore, this year, thirteen had very marked round shoulders. Three of these had unmistakable antero-posterior spinal curvatures. For the thirteen, Dr. Mitchell, the medical director, prescribed special treatment with medical gymnastics and the Zander machines. Their improvement is already great. Eighty-nine of the freshmen (out of one hundred and thirty) had left shoulder higher than right. These pupils had come from the public schools of Baltimore and other cities. Still another class of girls at the Bryn Mawr Preparatory School, Baltimore, were measured and their bare backs carefully noticed. When the new building was opened, and the gymnastic work instituted, the first measurement of the hundred girls from 10 to 18 years of age showed the following: Fifty-four had left shoulder higher than right. There were three cases of lateral spinal curvature, and sixteen cases of marked round shoulders.

Nearly every girl in the school was given a prescription card containing the order of her special exercises for the cure of high shoulder or any weakness of bones or muscles, chest, throat or back. The results have been most satisfactory. Of the sixteen cases of round shoulders in 1891, eight remained in 1892, and there were only four in September, 1892, two of these being new pupils. Of the three cases of lateral curvature of the spine, two are perfectly cured. No brace or corset was used in either case. The third case was put into braces by the family physician, taken away from the gymnasium because he could see no improvement at the end of a months' exercise, and is still wearing the same brace.

At the "Sept., 1892," measurement, only fifteen were found to have the left shoulder high. That the gymnastic exercises have corrected the deformities seems quite certain; inasmuch as the girls still sit more or less unevenly at their desks, though the desks and chairs are adapted to the individual pupils, and the lighting of the room comes from the left and back, a good northwest exposure. There seems to be a careless habit of sitting half on the chair with the right hip drooping, causing the prominence of the left hip. The body is twisted toward the right, the left arm rests on the desk, while only the wrist of the right hand touches the edge of the book in studying or writing. It has been almost impossible to persuade the pupils to carry their books back and forth from their homes in a Boston bag; they prefer to load their left arms with the pile as the public school girls do.

As to the universally bad positions in writing it is said that Shenck, of Berlin, found only six children out of two hundred who sat without twisting their bodies in writing. Owing to this observation the school teachers in Berlin were ordered to see that the children sit squarely and write with *perpendicular strokes*. There is no reason why Bryn Mawr School girls should not be strong if health depends upon school life. The school building is perfect in construction, in heating and in ventilation. The gymnasium is a model in arrangement and furnishing; the swimming pool and shower baths meet every requirement of health and æsthetics. The play ground with its two concrete tennis courts; the archery range; the ivy banks and comfortable seats, make the recess out of doors delightful in spring and fall, and furnish a chance for play in the heart of this great stone city.

The general health of the pupils is much improved despite the fact that they are passing through the most critical period of their girlhood. The number of absences can not be compared with those when in the old building, because every year one or more pupils return late in the fall, or leave early in the spring, for the sake of teaching in this country or in Europe as a part of their education. It is worth while to note that ten pupils who suffered from habitual headache have been put into glasses and are entirely cured. Thirty pupils who have slight astigmatism or unequal vision are being carefully watched for symptoms of eye strain, but it is not thought necessary yet to put them into glasses. Nine extremely nervous girls have become strong and well. Two who stammered badly

now talk easily except on rare occasions. Four who were subject to bronchitis have not been absent this year on account of colds. Four who had functional heart disease have lost all trace of the trouble and are as rugged as any of the others. One pupil who has serious organic heart lesion from scarlet fever has not been absent this year from ill-health. There has been no epidemic of scarlet fever or measles, although two pupils had these diseases last year.

Backaches and sideaches from running, growing pains, and other symptoms of muscular and nervous irritability are almost things of the past. There have been cases of anæmia, one death from typhoid fever and one from phthisis, one case of chorea, two cases of menorrhagia and two of dysmenorrhœa. These pupils were all delicate in constitution and were not allowed by their family physicians to take gymnastic exercises or swimming. They were generally allowed to come to school without eating breakfast; they often brought no lunch, and sat up as late at night as they pleased, to study or go to theatres. It is not probable that their spasmodic school life was to blame for their ill-health. The conclusions to be derived from these facts are plain. Hygiene and mechanico-therapeutics can accomplish wonderful results in improving the health of the school children. Let us then have men and women trained to be medical directors of schools. Let the best attention be given to the welfare of the entire being and to the development of true symmetry in manhood and womanhood. Let the city fathers appoint medical supervisors as well as teachers. Let the trustees of universities provide for the instruction of such supervisors here in America, and then let us expect to have a generation of strong and healthy men and women, while pills and powders grow old and decompose on the chemists' shelves.

Mr. Edward Atkinson has written a letter to the Boston *Herald* anent the recent fire in Boston. He uses the fire as an argument in favor of his proposed system of roof hydrants, which was noticed in these columns a few months since. The facts given by Mr. Atkinson make a strong case in favor of some better means of getting water on a fire. He claims that a great many mill-yards in New England are so equipped that more water can be thrown from the mill hydrants upon the vantage points than the whole Bostan fire department can concentrate upon any one of these points. This is certainly worthy of consideration. Mr. Atkinson says that only a small part of the water thrown on a fire from the street level does any good, and further that the firemen nearly always endeavor to get streams on the fire from the roof or some point where they can see how to place the stream to the best advantage. The water-tower is an attempt in that direction, though in a Boston fire it was rendered ineffective by the net-work of wires which cumbered the street. Mr. Atkinson claims that a system of roof hydrants could be established at a cost of $2,000 per acre of roofs. Had such a system been in operation in Boston he thinks the flames could have been confined to the building in which they originated.—*Ex.*

Garlic is the latest remedy guaranteed to cure cholera. This ought to do it, sure! What well-bred and self-respecting bacillus of standing in the pathogenic fraternity could face such an enemy?—*Ex.*

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BALTIMORE, MARCH 18, 1893.

Editorial.

LAZINESS.

An extract given in a recent issue directs our attention to this most fatiguing subject. If there is anything that makes a man very tired, it is to have to wait for a man who is constitutionally still more tired. And one's opinion of his own virtue is at its highest when he feels called upon to criticize an acquaintance as "the laziest man on this earth."

But the question of "laziness," like the question of the drink habit, is one that demands very serious attention from the physician; for although the culpable form of laziness is a vice that indicates moral obliquity, there are states of inertia, often mistaken for the former, which are really an indication of disordered health.

When we cause to pass before our mind in review the cases of most notorious and intense "laziness" which have come to our notice in past years, we are inclined to resolve that in future we will be very slow to join in branding a fellow-man as "lazy."

We have come in contact of course with numbers of persons whose laziness partook of the nature of "pure cussedness," being the outcome of dissipation or drug habits; the nervous energy being consumed in unwholesome indulgences and the moral nature greatly degraded.

Apart from such cases, however, we recall several instances of persons apparently free from vice, who had the reputation of being unconscionably lazy.

For the indolence of one, a healthy physician, who began in middle age to neglect a good practice and sponged a living off his not-rich wife until extreme old age, we have never heard any cause given. He seemed to be afflicted with laziness in its purest form.

The others all had cause for their indolence. One, a countryman, who was

thought to be sadly lacking in energy, confided to us some time ago that he was compelled all the time to wear a large wooden plug in his rectum on account of prolapse of its tissues. Even the most ardent enthusiast could hardly expect a man to be excessively energetic under such circumstances.

We knew some time ago a very inactive man who had, unknown to the public, a hernia to contend with.

There were two instances, somewhat resembling one another, which greatly baffled our efforts to divine the source of indolence. Both were strong, healthy men who lived off the scant earnings of their sisters. They seemed to have no vices, but to be quite intelligent on other matters than the duty of earning a living. The whole matter was made clear in each case when we heard that each of the men had a pension from the National Government, about sixty dollars a year, in one of the cases. This possible cause of laziness should never be forgotton by the investigator of the problem before us, especially in these days of "billion dollar" congresses.

A very curious form of inactivity is found, not necessarily connected with pensions, for it is to be observed in Confederate as well as Union veterans, in soldiers who went safely through our civil war, but seemed to be ever afterwards destitute of energy. Perhaps they overdrew greatly their nervous and moral force in the struggles of that period, and have not been able in the twenty-seven years which have elapsed to find a new supply of it.

Our private opinion, deducted from the above observations, is, that if a man loses inclination for work, who is not dissipated or morally depraved, has no hernia, does not wear a rectal plug, is not a physician, and does not draw a pension, he is probably suffering from some obscure disease and should receive careful medical examination and treatment.

Pan-American Congress.

PRELIMINARY MANIFESTO OF THE SECTION ON DISEASES OF THE MIND AND NERVOUS SYSTEM.

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Every physician on this continent of America, North or South, is hereby cordially solicited and welcomed to join in the meetings of this important section of the approaching Pan-American Medical Congress, and it is hoped by unity of effort and cordial co-operation to make the section of nervous and mental diseases second to none in the Congress in fruitful results to Pan-American psychiatry.

Valuable papers have been promised from distinguished savants in neurological and psychological medicine, but many more are desired and desirable. The Spanish, French and English languages will be spoken in the section, and it is especially desired to secure as good a representation of the profession and make as good an exhibit of the advance in neurology and psychiatry as may be possible.

Letters, applications for membership, advice, etc., should be sent as early as possible to Dr. C. H. Hughes, 500 N. Jefferson Ave., St. Louis; or to Dr. A. B. Richardson, Columbus, Ohio.

OPHTHALMOLOGICAL SECTION.

Dr. Julian J. Chisolm, of Baltimore, who is Chief of the Ophthalmological Section of the Congress, has organized his Department with the following gentlemen, well known as ophthalmic surgeons: Dr. George M. Gould, of Philadelphia, English-speaking Secretary; Dr. J. Harris Pierpoint, of Pensacola, Spanish-speaking Secretary.

The Honorable Presidents of this Section are: Drs. Herman Knapp, New York; Eugene Smith, Detroit; Stephen C. Ayres, Cincinnati; J. L. Thompson, Indianapolis; X. C. Scott, Cleveland; Abner Calhoun, Atlanta; Herbert Harlan, Baltimore; Charles W. Kollock, Charleston; Stephen C. Richey, Washington; Jose Ramos, City of Mexico; G. C. Savage, Nashville; J. E. Minney, Topeka; W. H. Carmalt, New Haven; B. J. Baldwin, Montgomery; Aurelio Alarce, Lima, Peru; Charles Finley, Havana, Cuba; Hasket Derby, Boston; J. C. Kipp, Newark; Dudley S. Reynolds, Louisville; Maximo Cienfuegos, Santiago; F. C. Hotz, Chicago; Charles E. Michel, St. Louis; Samuel D. Risley, Philadelphia; R. H. Lewis, Raleigh; T. E. Murrell, Little Rock; E. C. Rivers, Denver; C. M. Shields, Richmond; J. F. Fulton, St. Paul.

In the Advisory Council are the following ophthalmic surgeons: Drs. Adolph Alt, St. Louis; L. Webster Fox, Philadelphia; George T. Stevens, New York; Edward Jackson, Philadelphia; B. A. Randall, Philadelphia; H. V. Wurdemann, Milwaukee; F. Sattler, Cincinnati; L. Connor, Detroit; Hiram Woods, Baltimore; R. L. Randolph, Baltimore; J. A. White, Richmond; S. M. Burnett, Washington; A. R. Baxter, Cleveland; J. P. Parker, Kansas City; J. J. Thompson, Kansas City.

Medical Progress.

CASE OF UNILATERAL ABSCESS OF THE TONGUE.

Dr. Lockwood, of Lockeport, writes as follows to the *Maritime Medical News:*

"Abscess of the tongue," Erichson says, "though rare, occasionally occurs." Of this affliction, Holmes Coote, in Holmes' System of Surgery, has the follow-

ing:—"I have seen several cases of abscess of tongue"—"and a case of unilateral abscess of that organ is reported in *Lancet*, 1877, page 855."

Bryant mentions abscess of tongue as occasionally following a severe glossitis.

Considering the rarity of this disease, the following report of a case may be of some interest:—

N. C., male, age 19, of good family history, had never suffered from disease or injury of any kind until the present trouble.

When first seen, the patient complained of soreness of the tongue, and on examination this was found somewhat swollen, slightly tender, and covered with thick brown coating. There was no evidence of injury from the teeth or otherwise.

It being at first thought that the disease was caused by a disturbance of the general digestive system, bismuth, rhubarb and soda was exhibited with an astringent and antiseptic gargle for the mouth.

The tongue, however, continued to grow worse, and the patient presenting himself for further treatment, the right half of the tongue was found much swollen, and very tender, with enlargement of sublingual and submaxillary glands on the same side. There was also a severe right otalgia and difficulty of mastication.

Anteriorly and on the under and right side, close to frenum, a small fluctuating area was noticed.

The point where the fluctuation could be detected being near the ranine artery, it was decided to wait until swelling became more prominent before incising. In the course of forty-eight hours, however, there was a spontaneous evacuation of pus at this point, which continued discharging freely for some days, to the great relief of the patient.

One week after this first discharge pus again found exit at the upper and posterior part of the right tongue. Both openings continued discharging for seven or eight days longer, when all symptoms declined and the patient soon recovered his usual health.

The cause of abscess in this case is obscure, but the fact of the affection being unilateral would exclude sequence to general glossitis.

FORMS OF CHRONIC CHOREA.

A report of cases of the hereditary form of chorea does not afford a very wide scope for discussion; but there are problems in the relation of the forms to each other and to chorea minor, which, if I have read the literature aright, are still far from settled. My own point of view may be briefly stated: Chronic progressive chorea is a malady distinct from the various disorders associated with coarse lesions of the motor centres or path known as symptomatic chorea—an affection which (like forms of muscular atrophy) may occur in families or in single individuals, and is characterized by irregular, inco-ordinate movements, a reeling gait, speech disturbances, and progressive impairment of the mental faculties. The movements differ from those seen in chorea minor, being slower, and resembling rather those of Friedreich's ataxia, without the brusque, jerky character of the former disease. Moreover, in striking contrast to the movements of chorea minor, those of chronic progressive chorea are sometimes influenced by the will. A certain number of the cases of chronic chorea beginning in infancy and childhood belong to this category, but a very much larger number are instances of spastic paraplegia or diplegia; while others represent anomalous forms of chorea minor.

Chronic progressive chorea is, I believe, a disease wholly apart from the affection described by Sydenham, having nothing in common with it but the name. The course of acute chorea minor, the incidence in children, the arthritis, the seasonal relations, the extraordinary frequency of endocarditis—to say nothing of the different characters of the movements above referred to—separate it as a well-defined affection, depending possibly on a virus as yet unknown.—From an article by Dr. William Osler in *Journal Nervous and Mental Diseases*, February.

TREATMENT.

In regard to the treatment, Dr. Osler expressed, in discussion of the paper, the following sentiments: With our ample experience of the course pursued, no one should attempt to treat medicinally a case of chronic chorea. A physician should have the courage in these cases of chronic progressive affections of the nervous system, to say to the patient: "My good fellow, there is nothing to be done for you. Go home, arrange your affairs, live a quiet life, and do not throw away your money on medicine, particularly quack medicine." Unfortunately chronic chorea contributes only a small part of the cases of chronic disease of the nervous system for which we can do very little. This is regarded as a great reproach to medicine. We cannot be expected to cure all cases; as old Sir Thomas Browne said two and a half centuries ago: "There are vices incorrigible in divinity, cases indissoluble in law, and diseases incurable in physic," and they will remain so.

A NEW AND RAPID METHOD OF REMOVING THE UTERUS.

At a recent meeting of the Kansas City Academy of Medicine, Dr. Emory Lanphear presented a number of fibroid tumors, sarcomata, etc., removed by a new method of abdominal hysterectomy. The abdomen and vagina having been carefully sterilized, he makes an incision in the median line terminating as close to the pubes as possible, draws the uterus with one tube and ovary to one side and applies a clamp to the broad ligament; a strong ligature is passed a half inch from this, including the blood vessels, and tied; the intervening tissue is then cut with scissors. Upon the opposite side the same procedure is carried out. When done, the uterus (hitherto held down by the broad ligament) can be lifted up into the wound and separation from bladder and rectum easily accomplished; these incisions, before and behind, are carried into the vagina, when a Kelly's or Polk's clamp is introduced through the vagina as close as possible to the uterus, its points reaching the ligature already tied, in the broad ligament. As soon as properly applied it is closed and its fellow clamp inserted upon the side, when the uterus is quickly cut away with curved scissors. The pelvis is irrigated and the abdominal wound closed and drainage made through the vagina as in cases of vaginal hysterectomy. The clamps are removed in 48 hours. The operation can be done in 25 to 30 minutes, being much easier than even vaginal hysterectomy with clamps. By the rapidity allowed and by the good drainage secured, Dr. Lanphear thinks this operation can be done almost as safely as an ovariotomy—certainly as safely as a vaginal hysterectomy; and it is much preferable to any method which leaves a pedicle or stump behind, He finds it is not necessary to unite the bladder to the rectum, as union takes place just as quickly without sutures as with them.

A CASE OF SYMPHYSIOTOMY.

At the December meeting of the Montreal Medico-Chirurgical Society, Dr. J. A. Springle gave the following history:

Mrs. M. L., primipara, aged 25, of Irish parentage, gives the following history:

She has been healthy up to her marriage, four years ago; since then, to the date of her pregnancy, she has suffered from what a local gynecologist pronounced to be pyosalpingitis. However, she became pregnant, and appeared to do well.

On the 4th inst. slight labor pains were experienced, and the liquor amnii began to flow away. I saw her on the morning of the 5th, and labor was then active, but os uteri not fully dilated. The pelvis was found to be generally contracted. At 3 A. M., dilation being complete, an effort was made to extract with forceps, but without success. At 9 A. M., Drs. Lockhart and Kenneth Cameron saw the case. The uterus was then tightly contracted upon the child, whose head was tightly filling the inlet. It was easily seen that the pelvis was too small to extract, and symphysiotomy was decided upon.

A median incision over the symphysis, extending three-quarters of an inch above this and passing slightly to the left of the clitoris, was made down to the bone. A vulcanite rod in the urethra drew it over to the right, and depressed it away from the incision. Above the pubis the incision was deepened until the loose cellular tissue was reached. The left forefinger was then passed behind, and the position of the urethra being ascertained the symphysis was cut through. The two sides sprang apart, leaving an interval of over one inch. A pad was placed over the wound, and the fœtus rapidly delivered with forceps by Dr. Lockhart, proper support being given laterally to the pelvis. The child was in good condition, and not disfigured by the instruments.

The total time was one hour and a quarter from the commencement of the operation until all dressings were completed.

Both mother and child have done well since. There is considerable pain about the left sacro-iliac synchondrosis, due, I believe, to rupture of the anterior ligaments.—*Montreal Medical Journal.*

INJECTIONS OF CEREBRINE.

The most notable effects on the human system of a single dose are as follows—though in very strong, robust and large persons, a somewhat larger dose is required, never, however, exceeding ten minims.

1. The pulse is increased in the course of from five to ten minutes, or even less in some cases, by about twenty beats in a minute, and is rendered stronger and fuller. At the same time, there is a feeling of distension in the head, the perspiration is largely increased, the face is slightly flushed, and occasionally there is a mild frontal, vertical, or occipital headache, or all combined, lasting, however, only a few minutes.

2. A feeling of exhilaration is experienced which endures for several hours. During this period the mind is more than usually active, and more capable of effort. This condition is so well marked that if a dose be taken about bedtime wakefulness is the result.

3. The quantity of urine excreted is increased, when other things are equal, by from 8 to 12 ounces in the twenty-four hours.

4. The expulsive force of the bladder, and the peristaltic action of the intestines, are notably augmented, so much so that in elderly persons, in whom the bladder does not readily empty itself without considerable abdominal effort, this action is no longer required, the bladder discharging itself fully and strongly, and any existing tendency to constipation disappears, and this to such an extent that fluid operations are often produced from the rapid emptying of the small intestine.

5. A decided increase in the muscular strength and endurance is noticed at once. Thus, I found in my own case that I could "put up" a dumb-bell weigh-

ing forty-five pounds fifteen times with the right arm and thirteen times with the left arm, while after a single dose of the extract I could lift the weight forty-five times with the right arm and thirty-seven times with the left arm.

6. In some cases, in elderly persons, an increase in the power of vision is produced, and the presbyopic condition disappears for a time.

7. An increase in the appetite and digestive power. Thus a person suffering from anorexia and nervous dyspepsia is relieved of these symptoms, temporarily at least, after a simple dose hypodermically administered.—Dr. Hammond, *Va. Medical Monthly*, March.

INFLAMMATION.

In the twelfth volume of his *Beitrage*, Zeigler gives a valuable review on inflammation. He speaks of the difficulties which are met with in attempting to define inflammation. The difficulty of the definition is that the term embraces not a single phenomenon, but a sum of pathological processes. He then takes up the essential phenomena of inflammation and the various ideas which have been held with reference to them. An attempt to give a precise definition of the nature of inflammation must always take into consideration the entire process which the clinician designates as inflammation, and not single pathological phenomena. Metschnikoff, in studying the relation of the tissues towards foreign irritants, regards the collection of phagocytes or leucocytes around the irritating body as the essential moment. In many cases of inflammation this process of phagocytosis which he regards as characteristic of inflammation does not take place, while on the other hand, extensive phagocytosis is seen in processes which should not be classed with inflammation. There are two phenomena which are always present in inflammation, the local degenerative disturbances of nutrition and pathological exudation from the blood-vessels. The injuries which excite inflammation first affect the tissues, but they can also have an immediate action on the walls of the vessels. This latter takes place when the injurious material is contained in the blood and from there comes in contact with the walls of the vessels. All injuries which are followed by the clinical phenomena of inflammation produce a local degeneration of the tissue, and the disturbances of the circulation are in some way connected with the degeneration. Not all local disturbances of the circulation can be considered as inflammation, but only those in which there is at some time a pathological exudation of the constituents of the blood. The essential disturbance of the circulation which we meet with in inflammation is characterized by a slow blood-current in widened arteries, and by the exudation at the same time of a fluid relatively rich in albumin and colorless blood-corpuscles, sometimes also containing red blood-corpuscles.

In the formation of the pathological exudation there are three different processes which may be separated from one another. The exit of the colorless blood-corpuscles, of the fluid, and the red blood-corpuscles. The author then takes up the various views as to the cause of the emigration of the colorless blood-corpuscles and the manner in which this takes place. Most of the authors at the present day regard an alteration of the walls of the vessels as a necessary prerequisite to the emigration of the leucocytes, but it is not possible to define exactly what sort of alteration of the vessels takes place. Whether nerve influence plays a role in the exudation it is impossible to decide. It is possible to imagine that the capillary secretion is influenced by the nerves, but still nothing is known of the presence of such nerves and there are no pathological processes which can explain the phenomena of exudation by nerve influence. The alterations of the tissue are in the first place degenerative, and only degenerative processes belong to inflamma-

tion. It is perfectly well known that multiplication of the tissue cells always takes place in inflammation, but this is not a necessary and essential part of the process. Most of the tissue changes in inflammation are to be regarded as degenerations which are brought about by the cause of inflammation or by the disturbances of the tissue produced by the inflammation, so that the growth of the tissue is only an accompanying phenomenon which is not necessary to inflammation and can be entirely wanting. The first appearance of the growth of the tissue takes place, at the earliest, eight hours after the action of the inflammatory cause, but in most cases much later, as in two or three days. In severe inflammations a large portion of the new cells of the tissue are destroyed. The exudation coming from the vessels in the first place is accumulated in the spaces of the tissue and in the lymph vessels or on the surface of an inflamed tissue and organs, but it must be added that a part of the exudation is also contained in the tissue itself, that is, in the cells. The older theories of inflammation only concern themselves with the free exudation. Virchow was the first to show that the exudation could be contained in the tissue itself, and the importance of this. Of late, the idea that the inflammation has a purposeful character, having for its object the removal of the conditions which were exerting an injurious influence on the tissues, comes more and more to the front. Thus Leber says, that, in consequence of the action of external injuries, certain vital phenomena of the organisms are aroused, which serve to take away the injurious influences or their effects, just as the absence of oxygen by excitation of the respiratory centre causes increased respiration. This idea is not a new one, however; it is found in many of the older theories of inflammation, and Virchow in his first publication on inflammation expresses a similar view. The primary action of all inflammatory causes is seen, in the first place, in the production of a solution of continuity or a defect. Even electricity can only excite inflammation when it destroys tissue; and heat and cold also can only excite inflammation by producing a necrosis of tissue. At the present time all are earnestly seeking some means of opposing the action of the infectious bacteria, and many assume that inflammationis one of the most valuable means for the removal of a local infectious focus. Most investigators consider that the favorable action of inflammation consists in the accumulation of cells, which by phagocytosis, and in other ways, destroy the injurious organisms. Others lay more stress on the fluid exudation, which washes out the bacteria from the tissue and sends them to the surface, or renders them inactive and destroys them.—Dr. W. T. Councilman, *Boston Medical and Surgical Journal*, February 23.

RUPTURE OF TUBAL PREGNANCY IN PRESENCE OF A PHYSICIAN.

In the *Virginia Medical Monthly*, March, is given by Dr. Hugh M. Taylor, of Richmond, the following graphic description: Mrs. H. consulted me first in my office; she was thirty-nine years of age; had been married eleven months; had menstruated regularly until her last period, which she passed without any show. She had just passed the time for her period—the second one she had missed—when I saw her. Supposing conception to have occurred ten days after the last normal menstrual period, we could count about fifty days, or seven weeks, of suspended menstruation. She did not think herself pregnant, because five or six times since she ceased to menstruate normally she had had some show, lasting several hours each time; and upon each such occasion she thought and felt as if she was going to be unwell. She had suffered decidedly from gastric disorders, and very often had paroxysms of cramp-like pains in the right iliac region, and almost constantly a consciousness of something wrong in that locality. To

lessen the significance of this last symptom, she said she had suffered with a pain in the right side at intervals for several years, and about two years ago consulted Dr. Hunter McGuire about it. She also said that Dr. McGuire had treated her for some uterine trouble five or six years ago.

An examination, which I had just made, failed to show an appreciable change in the breasts, vagina, cervix, or uterus, but to the right of the uterus, low down in the pelvis, there was easily detected, as the patient was then, a little mass about as large as an English walnut, and egg-shaped. What could it be?—an enlarged tube, ovary, appendix, fæcal mass, or displaced uterus? I thought the group of symptoms sufficient to warrant the conclusion that it was a case of tubal pregnancy.

I requested the patient to meet me the next morning at the office of Dr. Hunter McGuire. That night I was called out of the city, but, before going, I wrote to Dr. McGuire, asking him to examine the patient for me, and telling him of my diagnosis. Dr. McGuire saw the patient, confirmed the diagnosis of tubal pregnancy, and, of course, under the circumstances, united in urging immediate operative interference.

On my return to the city, after an absence of twenty-four hours, I went to see the patient, and was sitting by her telling her the nature of her trouble and the need of an immediate operation, and while occupied in breaking the sad news to her as gently as possible, she suddenly clapped her hand to the right side of her abdomen and cried out with pain, and was about to fall, when I caught her. My first impression was that she was fainting from fright and shock, but the profound and continued shock and collapse soon told the story of rupture, hæmorrhage, and shock and collapse incident thereto.

EXAMINE YOUR PATIENTS.

An interesting case was operated on by Dr. Gerster at the Mount Sinai Hospital, New York, last week, and one which should warn practitioners against treating diseases of the rectum without making an examination. The patient was a young man who gave a history of some rectal trouble which had been treated, without an examination, as hæmorrhoids by ointments, etc., for some time. On examination it immediately became evident that there were a large number of polypi in the rectum. When he was anæsthetized and the sphincters stretched, the rectum was found to be simply packed with polypi, varying in size from that of a peach pit to a small shot, and extending as far up the organ as the finger could reach. As many of them as could be reached were removed by ligation. About every two or three weeks the patient will again be anæthetized and any new growths removed. This treatment will have to be continued for a long time, as the very small tumors will have to grow to some size before they can be ligated. Too many practitioners are averse to putting their fingers in a patient's rectum and are willing to treat anything that gives a history of rectal trouble as "piles," and even then with an ointment that only lessens the patient's sufferings for a time, and has no real effect on the hæmorrhoids, if indeed it be hæmorrhoids that is troubling the patient. Only a short time ago, I saw a patient in one of the clinics who was wearing an ointment of some astringent variety over an ischio-rectal abscess. On being asked what he had that there for, he said, "the doctor gave it to me to cure my piles," but the doctor had never made an examination, and the patient had not the first sign of a hæmorrhoid, but was verging on septicæmia from the absorption of pus from the abscess, which "the doctor" was treating with an astringent ointment. Many say the rectum is too filthy a place to examine, but if those men

would examine a rectum after an enema, and then examine a leucorrheal vagina, which none of them seem to hesitate to do, they would see that the latter is by far the more disgusting organ of the two.—T. D. T., in *Southern Medical Record*.

Recommendations of Therapeutic Agents.

Sulfonal.—Sulfonal since its advent into therapeutics has been found to fulfil all the qualifications of a safe, reliable, and efficient hypnotic and antispasmodic. To use a trite expression, it fills a long felt want in this land of brain-workers where insomnia is one of the most common conditions which the physician is called upon to treat. Unlike other hypnotics, sulfonal when administered in moderate dose has no injurious effects on the circulation, respiration, digestion, temperature and general health, as pointed out by Dr. Joseph Collins (*Journal of Nervous and Mental Diseases*, July, 1892), and even excessive doses have given rise to only temporary disturbances. Drs. Roland G. Curtin and Richard W. Watson (*Am. Lancet*, March 12, 1892) consider sulfonal as the most safe and satisfactory drug for combating insomnia, as it is well borne even by comparatively weak hearts. Professor Emory Lanphear (*Kansas City Medical Index*), who has employed the remedy extensively in private and hospital practice, finds it a safe hypnotic of remarkable extrinsic value especially in cases of insanity and the most valuable remedy yet discovered to control insomnia in the morphine habit. Its advantages over other hypnotics are that it does not constipate as do the preparations of opium; the sleep produced by it seems to more closely resemble natural sleep than does that of any other drug; and having neither taste nor odor it is easily given in cases where patients object to taking medicines. In the hands of Dr. Barclay, President of the Aberdeen Medical Society (*Brit. Med. Journal*) sulfonal has proved the most successful of the hypnotic group, being especially beneficial in cases of delirium tremens and asthma, and Dr. S. E. Darling (*Med. World*) finds it valuable in children in quieting the irritability of teething, preventing convulsions and producing peaceful sleep. Dr. Graeme M. Hammond (*Denver Med. Times*) recommends sulfonal in 25 grain doses at bed-time in cases of insomnia in the opium habit, and Dr. E. P. Hurd (*Med. Age*) reports a case in which its use gave very favorable results. At the meeting of the American Medical Association in June, 1892, Dr. Edward Andrews related his experience with the remedy in controlling the cramps of fractured limbs and other reflex spasms, such as obstinate hiccough, premature ejaculation of semen in copulation, and in the discussion which followed other doctors bore testimony of the valuable antispasmodic effect of sulfonal. In various affections, such as chorea, epilepsy, tetanus neonatorum, excellent results have been obtained from sulfonal by various authors. As a sleep-producer after surgical operations this drug has been used in place of morphine in cases where severe pain is not present. Dr. Alexander J. C. Skene regards sulfonal as preferable to bromides, chloral and other combinations as a hypnotic after laparotomies, and his experience is confirmed by others. Finally, it may be mentioned that in that exceedingly intractable disorder—sea-sickness—this remedy has proved an excellent preventive.

An order has been issued by the German government that the Centigrade thermometer be exclusively used thoroughout the empire from the 1st of January next, instead of the Réaumur thermometer as heretofore.—*Cin. Lancet-Clinic.*

Medical Items.

Dr. G. H. F. Nuttall, of the Johns Hopkins Hospital, will sail for Europe in the early spring.

We beg to call to the attention of our readers the advertisement of "The Richard Gundry Home," appearing in this week's issue on page vi.

The *Baltimorean* reports that Dr. E. S. Dashiell and family, of Snow Hill, Md., have removed to Baltimore, where the doctor will practice his profession.

Dr. P. C. Williams and his son, Dr. J. Whitridge Williams, have removed their offices from 900 Madison Avenue, to 1128 Cathedral Street, corner of Howard Street.

Winternitz, of Vienna, has recently treated with great success several cases of renal disease with the extract of the wild filberry. Weil, of Berlin, claims that it has apparently cured a case of diabetes mellitus.—*Southern Medical Record.*

The January number of the *Alienist and Neurologist* is full of interesting and instructive matter. It contains also a short review of the life, work, and theories of the late Professor Theodore Meynert, "the greatest brain anatomist of all time."

Relying upon the professed high purposes of the Gladstone ministry, English philanthropists are beginning again to urge with vigor the abolition of the opium traffic, which former governments forced upon the ancient populations of Asia.

Governor Flower, of New York, during the cholera excitement, furnished the money to buy Fire Island, trusting to the State to reimburse him. He has recently sent in his bill with interest added at six per cent., which the representatives at Albany immediately reduced to five per cent.—*Ex.*

Dr. Emory Lanphear, of Kansas City, recently operated for the third time by the Wyeth method of amputation at the hip-joint. Not more than two ounces of blood was lost during the operation. The patient made a rapid and satisfactory recovery.—*Ex.*

Professor Horatio C. Wood, of Philadelphia, has declared strongly in favor of lancing the gums in children. He says he has seen convulsions, sick stomach, great restlessness, fever and other functional disturbances immediately cured by lancing the gums.—Kansas City *Medical Index.*

We had the pleasure of a visit this week from Dr. L. L. Pollock, representing the New York Pharmaceutical Co., well-known manufacturers of Hayden's Viburnum Compound and Uric Solvent. Dr. Pollock is a graduate of the University of Maryland, having obtained his degree in 1868, and has many friends among the profession of this city. He boasts upon this as being his best field for work.

The number of students in the Harvard Dental School during the past year has been fifty-one. A three years attendance is hereafter compulsory. The increase in the number of students and in the length of the course has necessitated an increase in the number of instructors. The Dean in his annual report refers to the project of a new building in a more central situation and better adapted to the growing necessities of the school.—*Ex.*

Dr. John Morris has suggested, in view of the national control of quarantine, that the city quarantine buildings and service be utilized for infectious diseases. When Mayor Latrobe was asked for an opinion on the question, he said: "I can not express an opinion, as I have not seen the national quarantine bill and the city quarantine service may have to be kept intact. I do not know that other cities will dispense with their local precautions."—*Sun.*

At a recent meeting of the Medical Society of the District of Columbia, held January 2nd, 1893, the following officers were elected for the ensuing term: President, Dr. J. Wythe Cook; Vice-presidents, Drs. Llewellyn Eliot, and J. H. Mundell; Treasurer, Dr. C. W. Franzoni; Corresponding Secretary, Dr. Thos. C. Smith; Recording Secretary, Samuel S. Adams; Librarian, Dr. Edwin L. Morgan; Board of Examiners, Drs. C. H. A. Kleinschmidt, W. Sinclair Bowen, Samuel S. Adams, George N. Acker and George C. Ober; Board of Censors, Drs. C. W. Richardson, Ernest F. King and John F. Winter.—*Va. Med. Monthly.*

The Florida Medical Association will begin its Twentieth Annual Session in Jacksonville, April 4th, 1893. Dr. R. P. Daniel is Chairman of Committee of Arrangements. The Secretary, Dr. J. D. Fernandez, of Jacksonville, in his preliminary circular, names Drs. R. A. Lancaster, of Gainesville; R. L. Harris, of Oakland; J. S. Herron, of Pensacola; Jos. Y. Porter, of Key West; and O. E. Worcester, of Conant, as chairmen respectively of the sections on medicine, surgery, gynæcology, hygiene, and diseases of children. Each chairman is expected to secure as many papers in his special department as possible, and send titles to the secretary, so as to be announced in the circular to be issued about March 15th.—*Ex.*

We learn from the daily press that Washington is about to obtain an Infectious Hospital from private enterprise. We believe that such hospitals are preferable to those built by the city governments in that they are free from political control. Our informant says: Mrs. Hitt's house was the rendezvous this afternoon for the members of the Daisy Chain Guild, an association of young people who hope to build a hospital for contagious diseases. The Guild has been in existence for several years and during that time has paid the expenses for kindergarten teaching at the Children's Hospital. The proposed building of a hospital for contagious diseases began to be talked of last year and the project has received the warmest support from a number of the most prominent people. Mrs. Archibald Hopkins, who has had active charge of the Guild since its formation, presided over the meeting this afternoon. The first business was the election of a president to succeed Miss Lena Morton, daughter of Ex-Vice-President Morton. Two names were placed in nomination and Miss Rochester, daughter of General Rochester, was elected. The financial statement read by Mrs. Hopkins showed that the guild had about $5,000 in its treasury invested in local securities. Part of this money was a gift of $500 each from Mrs. Carroll Mercier and Mrs. John Davis Jones, and $300 from Mrs. Ralph Cross Johnson. The pupils of Norwood Institute have raised $515, with which they intend to build one of the pavilions in the hospital grounds. The site for the hospital has been selected, and its cost, with that of the buildings necessary, will amount to $35,000. There were quite a number of prominent people in the audience this afternoon as well as the young members of the Guild, and Mrs. Hopkin's address was listened to with great attention.

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PAINFUL MENSTRUATION.*

BY J. M. HUNDLEY, M. D.,
Chief of Clinic, Diseases of Women and Children, University of Maryland.

The subject matter of this short paper, Mr. President and gentlemen, is one so full of interest to me that I thought it well to bring it before this society that I might get their full expression in the matter. The conclusions arrived at are from my own personal experience. I can only briefly survey the field, for it is a vast one. In this day of progressive medicine when one is ever striving to attain to some new end, to achieve some startling and brilliant result, old facts and theories which in times past have done us such good service are too often crowded out and lost sight of. As it is now, every doctor, and student even, has in his possession a speculum and probe. Not that it should be otherwise. They are invaluable aids when directed by a discriminating mind and an educated hand. But every ache and pelvic pain, whether occurring in a young girl just blooming into womanhood, or in one of maturer years, does not of necessity mean an examination.

I approve of vaginal and uterine examination, for by it alone are we en-

*Read before the Baltimore Medical Association, Feb. 13, 1893.

abled to treat intelligently those entrusted to our care. I do not know the experience of the older members of the profession; but when I see four young women in one year sufferers at each menstrual period, three of them having been under local treatment, one wearing a Hodge pessary, another having tampons applied twice a week, the third being "treated," as she said, how, I don't know; I think it well to ask, is this the universal practice? I examined these women carefully. The one wearing a pessary had a uterus slightly reclining in the pelvis and somewhat lower than the ideal; the second I found no trouble in, so far as I could judge; the third had some thickening in the left broad ligament; she was the one who was being "treated," and while I do not know, I dare say the treatment was the cause of the thickening; the fourth young woman had not been examined; she was 20 years of age, had been menstruating five years, painlessly, or nearly so. Some months prior to her visit to me she began to have pain and some little leucorrhœal discharge. A married friend had started her upon the use of a syringe with hot water and alum. She was bent upon having an examination made, as this friend had told her the trouble was more easily corrected at once than if allowed to run on and become chronic. After learning her history and finding she had been nursing for some months an invalid brother, that she was now nervous, easily irritated, etc., I assured her no examination was necessary, advised the discontinuance of the douche and put her on a tonic. I have heard nothing of her since.

Before proceeding further it will be well that we give some classification of the subject under consideration. That dysmenorrhœa, or painful menstruation, is a symptom only, we all know; while at times we will be unable to detect the causative influence, we should always be on the alert in the hopes of arriving at a proper diagnosis. In my early work I thought with an Ellinger dilator and curette I had nothing to fear, but I soon found out that I was wofully mistaken.

While it is convenient to give a classification of these disorders, it is well to bear in mind that there is often no well-defined line dividing them—the symptoms and conditions of one often merging into those of the other.

The varieties.—Some authors give four, others five. They are the neuralgic, congestive or inflammatory, obstructive or mechanical, and membranous. I will briefly take up each variety.

The neuralgic variety.—This variety in my experience is most frequently found in young girls. If an examination be made no organic lesion will likely be found. The subjects of this variety are neurotic, and this nervous condition may or may not be inherited. They are highly excitable, suffer from cold hands and feet; usually constipated and have flatulent dyspepsia. It is often caused by anæmia and chlorosis. They have neuralgias, headaches and other nervous affections. They are the sufferers of over-refinement and luxury as well as poverty, often have hysterical convulsions at the menstrual period and seem to suffer great pain.

Congestive or inflammatory variety.—The causes of this variety may be gen-

eral or local. It may be that at the menstrual period the physiological congestion consequent upon menstruation passes beyond its proper limits. In this variety women suffer some days before the flow; when it is established the pain usually ceases, though not always. The pain is usually referred to small of back and pelvic region; sometimes a sense of heat is felt in the back. The face may be flushed, skin hot, with a throbbing headache, and they may have some fever. The flow may be profuse or scanty; between the periods there is usually leucorrhœa. In this variety we find endometritis and chronic areolar hyperplasia playing an important part. It is claimed that plethora may cause this form. Malaria is said to be a factor in its causation. We all know that pelvic inflammations are potent factors; such as cellulitis, peritonitis and salpingitis. It is common to find women with adherent tubes and ovaries great sufferers. I have one such case now; before the flow she will ache all over as if she had muscular rheumatism, between the periods she gets along fairly well. Malpositions of the uterus are frequent causes, as retroversions, prolapsus, etc.

The membranous variety.—It is characterized by the expulsion at the menstrual period of organized membrane in whole or in part. I have never seen a case. It is more or less rare. I believe the membrane is now thought to be simply the lining of the uterus. Skene says: "It is clearly evident that there is nothing pathological in the condition of the mucous membrane itself, and that the whole morbid process consists in the separation of the membrane in mass, in place of disintegration, which is the normal character of the mucous membrane in menstruation." There are other views regarding the pathology of this affection. One, that it is the result of gestation, which is arrested at a very early stage, and that the membrane thrown off is really a decidua vera. Another is that it is an inflammatory affection. This affection occurs in single and married women and in those who have borne children, but in most of the cases occurs in married women who have been sterile. We are still in ignorance as to the causation. The latest hypothesis is that it is due to ovarian influence, the condition of the ovaries being that of an undue nerve excitation and possibly congestion.

The fourth variety.—Mechanical or obstructive dysmenorrhœa may have for its causation fibroids distorting and polypi closing up the canal, stenosis of internal or external os, occlusion of the os from use of strong caustics, etc. Also from anteflexion and retroflexion and version.

Diagnosis.—To find the etiological factor in a given case is often most difficult. In text-books the character of the pain is dwelt upon as if it aided in diagnosis. It has been of little assistance to me. If a woman has paroxysmal pain and with the pain a gush of blood, or the extrusion of a drop or two, one would think there was an impediment to the flow. In my experience he would be as often wrong as right; for I have seen women suffer the greatest agony, with pains like labor pains, and after their menstrual period examine them and find a freely patent os, and beside, an adherent ovary and tube, which was no doubt the cause of the pain. In that there is no way to arrive at a correct diagnosis save

by an examination, are we justified in making such examinations indiscriminately? We all know that the majority of young women suffer more or less pain at each menstrual period. Let such a woman marry she soon becomes pregnant, and there is an end to her suffering usually. My idea in discussing this point as to whether examinations should be made on the young woman as well as those that have suffered years, be they single ormarried, before exhausting every means known to therapeutics, is, as stated above, in giving the histories of the three young women coming to me in the past year; and in stating my position more clearly, I here say that no one in my judgment has a right, unless there be some reason to suspect serious organic lesions, to examine young unmarried women who suffer pain at each menstrual period. All of us I am sure can recall cases where the woman has suffered for months; I am alluding especially to the young unmarried women; look after her general condition, with possibly a trip from home; the pain ceases, and she may go for months without its return. Of course making up one's mind in each individual case as to the proper course to pursue often calls for experience and good judgment. If a woman comes with a history of many months' suffering, be she young or old; if the pain is telling on her general condition, and we have every reason to believe that her case has been properly treated; then it may be incumbent upon us to make an examination. I find in dealing with women that the mental condition produced by the belief that they have womb disease is frequently far worse than the trouble itself; hence we as physicians should be careful and not give a diagnosis of disease when there is some trivial condition, which often does as well let alone as treated. In one of the three cases related above—the one with a Hodge pessary—I assured her that there was now no trouble, that the condition had been cured calling for the pessary and it was no longer of use. I simply looked after her general condition; she was very nervous, and so far as I know she is doing well.

Treatment.—For the successful treatment of painful menstruation one should be thoroughly acquainted with the general as well as the local conditions giving rise to the affection. There is great diversity of opinion as to treatment. One class of specialists, Dr. Emmet heading the list, believes that mechanical dysmenorrhœa is a myth. Fifty per cent. of women with acute anteflexion examined by him had no pain at their menstrual periods. From my limited experience, certainly in young girls, we have all we can desire in the medical treatment of the affection; and if, as I believe, the pain manifested in this class of subjects be due to a neurotic condition, to poor development of their general physical structure, to sedentary habits, to insufficient out-door exercise, etc., the treatment is clear. For the relief of pain at the time, opium is the most certain and efficient, but we should hesitate and think well before prescribing either it or chloral. We have other agents, if not as efficient, certainly less harmful. If the flow be free, cannabis indica with bromide of potash often allays the pain. In spasmodic cases belladonna and hyoscyamus, antipyrin and pulsatilla in tincture; also if there be any rheumatic history, tinct. cimifuga. Apiol administered a few days prior

to flow is said to be of benefit. I have tried it often and found no advantage from it. If the extremities are cold and surface pale, nitro-glycerine acts well. Rest in bed should be enforced and dry-heat applied; whiskey and teas I think are bad. One lovely girl of high social position is now at Dr. Mitchell's in Philadelphia, hoping to be relieved of the dreadful condition she is in from the too free use of whiskey at her menstrual periods, the habit growing on her. In the interval every means should be used to build up the general health, iron, binoxide of manganese, nutritious diet, change of surroundings, massage in a certain class, and in still another class the "rest cure." In fact, any and everything that will tend to put the woman in the best possible condition. Every drain upon her vital powers should be interdicted. In speaking of remedies, I forgot to add that if the flow be free, instead of iron, quinine and arsenic should be given. No local treatment is needed in these young women; it will do more harm than good. I have now a young girl under treatment who has been suffering for months. She came to town two weeks ago, has been unwell since she has been here, and almost without pain. She thinks what I gave her was the cause; of course it can't be, as the time has been too short; it was simply due to her trip and the belief she would be cured. She is one of the three alluded to above, and the one having tampons applied, for what I don't know; she had no more than a normal flexion. I am aware of the fact that freeness from pain at a menstrual period is not a positive proof of the non-existence of mechanical obstruction. Certainly there are conditions calling for both local treatment and surgical interference, such as endometritis, erosion of cervix, metritis, periuterine disease, areolar hyperplasia, malpositions of the uterus, etc. In how far anteflexion proves a barrier to the free outflow of blood is a mooted point. I shall have but little to say of the surgical treatment of painful menstruation. I have examined a great number of women, and not only examined them but taken the trouble to record their full histories often, and often in examining women, I would say, "you suffer pain at your periods;" the answer would be, "no." I would say to those around me, if this anteflexed uterus, almost doubled on itself, does'nt give pain at the menstrual periods, I can't believe hereafter in mechanical dysmenorrhœa.

There is much in this trouble concerning which we are still in the dark. You will find one woman with her uterus, ovaries and tubes bound up in one mass almost and she will menstruate almost painlessly. Another with a left adherent tube and ovary suffers agony. There is something in the woman other than the local condition. Her nerves are at fault. I should dilate an anteflexed uterus if drugs availed nothing. If that failed, I should do a Dudley operation, which is nothing more than a modified Sims operation. But, in dilating and doing the Dudley operation, if my patient was cured I would consider myself very fortunate indeed. Some are cured by such means, but in my hands I have oftener failed than succeeded. It may be the fault of the operator. I recall to mind now a woman whom I treated at the dispensary for a year with medicine. She came back each time no better. We dilated her cervix, curetted and packed the

uterus; still she suffered. She was lost sight of until one day I got a hurried call, and when I reached the house found she was in labor. At that time so much interested was I in the subject, I asked if her last menstrual period was painful; she said, "as much so as any she had ever had."

In closing this brief review of painful menstruation I will offer for your consideration the following conclusions;

1. That no young unmarried woman, though she may have pelvic aches and pains, and suffers at each menstrual period, should be examined until every means known to therapeutics is exhausted. That pain of itself at that time does not indicate necessarily disease of the uterus or its appendages. We can not detect it if it exists.

2. That anteflexion of the uterus *per-se* is not the cause of the pain suffered at the menstrual period.

3. That the treatment of anteflexion by dilating and curetting—and by the more radical operation, known as the Dudley operation—gives only a small percentage of cures. That the treatment by drugs and attention to the general welfare of these young women gives us the best results.

4. That where we find old exudates of inflammatory origin, together with adherent tubes and ovaries, massage offers, most probably, the best hope of cure. I do not mean pus tubes.

5. That no woman's ovaries should be removed on account of painful menstruation.

6. That every pathological condition should receive due attention in so far as it is conducive to the best interests of our patient.

A DANGER TO SURGEONS.

An interesting observation made by Professor Albert on himself emphasizes the importance of caution on the surgeon's part in the use of poisonous antiseptics, especially corrosive sublimate solutions. At a recent meeting of the Vienna Medical Society, the professor stated that for some time he had suffered from dyspepsia, for which no cause could be assigned by the physicians he had consulted. Lately the condition had become very troublesome, and the thought had occurred to him that the constant and free use of corrosive sublimate in his operations might have some share in the causation of the dyspepsia, by reason of the absorption of small amounts of this drug. Accordingly he had his urine examined by Professor Ludwig, the entire quantity passed during twenty-fours hours being tested. The examination revealed the presence of iodide of mercury in quantities comparatively large, if the manner of absorption of the substance be considered. While Professor Albert is not positive that his dyspepsia is due to chronic mercurial poisoning, he thinks that the fact that his finger nails have lately become softer and that he has lost three healthy teeth seem to point in this direction.—*International Journal of Surgery.*

According to English law, if a house is let, furnished, it is implied that it is in sanitary condition, and the tenant may obtain damages for illness resulting from unsanitary state of the dwelling. If it is let unfurnished, then, except under certain circumstances, the owner is not supposed to tacitly guarantee its fitness for habitation.

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BALTIMORE, MARCH 25, 1893.

Editorial.

THE COUNTRY HOME FOR CHILDREN.

It has been said that in its ultimate development the great calling of medicine will have for its aim, not the *treatment*, but the *prevention*, of disease. Already we may see a large portion of the profession devoted to the promotion of sanitary reforms, and to the study of the agencies and methods by which disease is introduced into and distributed throughout the human system. And while the practitioner is endeavoring more and more earnestly to acquaint his adult patients with the avoidable causes of their ailments; the physician who is an enthusiast upon the subject of physical culture is striving to evolve methods by which increased vigor and resisting powers may be secured to the children, who will be the adults of the next generation.

The problem of health for the young is most difficult of solution in our great cities. Fresh air, clean homes, invigorating exercise and recreation, and wholesome food and drink—the necessities of health—are in great part denied to the children who are growing up in the small streets of our crowded city centers. How any of them reach vigorous maturity is an insoluble mystery.

The medical profession stands in despair before many of the diseases, or rather vices of constitution, which are bred in the child by continual exposure to dampness, filth, gloom and unwholesome diet. The many things which are necessary for the restoration of health are just what he is unable to give.

It is therefore with a deep sense of gratitude that our profession witnesses the efforts put forth by persons who have leisure and can obtain the money, in the establishment of great enterprises for the improvement of the vital conditions of the children of our city poor; and it seems but natural that woman should take the lead in this matter.

Among the various movements to this end with which we are acquainted, none

appeals to us more strongly than the Country Home for Children. We visited the Home last summer (as recorded in a previous editorial), and can bear witness to its beautiful location and healthful surroundings.

We have before us the sixth annual report of the Home. It is situated at Orange Grove station on the Baltimore and Ohio Railroad, two miles from Catonsville. About two hundred children were given a vacation there—boys and girls separately—last summer. The continuance of interest in the enterprise is assured by the youth of the managers; while wisdom in its guidance is secured by association with a staff of older ladies. The immediate charge of the children is at present committed by the managers to All Saints Sisters. The medical supervision necessary in selecting the children, who must be free from contagious diseases and in sufficient health to get about by themselves, is exercised by Drs. Charles and John O'Donovan, of Baltimore City.

The managers propose by next summer to extend and remodel the Home at a cost of $11,000. This will give much larger accommodations, including baths, play-rooms, broad porches, etc.

We invite our readers to bear the Home in mind, for the benefit of their little patients, during the coming summer. The Chairman of the Admission Committee is Mrs. Edward R. West, Catonsville, Baltimore Co., Md.

THE CORRECTION OF "DISPENSARY ABUSE."

We note with pleasure the efficiency attained by the Presbyterian Eye, Ear and Throat Charity Hospital, as shown by its 15th annual report. This institution is a great credit to our city and an important agent in the training of young specialists. No stronger evidence of the inestimable blessing conferred by it upon the community is needed than the simple statement that six hundred infants have received in it treatment for ophthalmia neonatorum, a disease which is the cause of one-fourth of all cases of blindness in after-life; and that in these patients not a single eye has been lost when they were brought to the hospital before any serious damage was done.

It is with especial pleasure that we note the disposition of the management to grapple with that most difficult problem, the abuse of dispensary privileges by well-to-do patients. After a greater or less experience of the difficulties, most dispensary physicians "give it up," and make no effort to turn away persons able to pay for their services. In fact this burden ought not to rest on the physician at all, since he has already enough to do in the proper treatment of the patients. It ought properly to be borne by the management of the dispensary.

At the Presbyterian hospital, according to the report before us, this method has been finally adopted. Formerly the member of the medical staff of the dispensary to whom they applied, on grave suspicion that the patients were well-to-do, sent them up town to his private office and made them pay for his services according to their ability. Now a different plan has been adopted. A non-pro-

fessional gentleman is employed to interview patients whom he suspects to be able to pay; and, if his suspicions are confirmed, to inform them that they must get professional advice outside of the dispensary. Many hundreds of patients were thus turned away during 1892.

Reviews, Books and Pamphlets.

A New Text-Book of Anatomy. Just issued by P. Blakiston, Son & Co., 1012 Walnut St., Philadelphia, 1893. Written by ten of the foremost anatomists and surgeons of the English-speaking world, and edited by HENRY MORRIS, F. R.C.P., Surgeon to, and Lecturer on Surgery at, Middlesex Hospital, London; Examiner on Anatomy in Royal College of Physicians and Royal College of Surgeons, etc. It contains 1280 pages and about eight hundred illustrations, 214 of which are printed in several colors, and all, with few exceptions, drawn and engraved expressly for this work. Many are original and made directly from actual dissections by the authors. The work has been done by special artists and no pains have been spared by the authors to make each cut clear and representative of the normal structures and relations. Engraving of names across the illustrations has been avoided, and the exact locations made clearer by leading lines to marginal names. Many of the cross-sections and positions shown are entirely new, and the result of careful study to make the book as a whole represent the most modern methods of studying and teaching anatomy. Printed from clear type on the best book paper; Royal 8vo. Cloth, $7.50; Sheep, $8.50; Half Russia, $9.50. The arrangement of subjects and their authors is as follows:—

Osteology (Bones); by J. Bland Sutton, F. R. C. S., Lecturer on Comparative Anatomy, and Senior Demonstrator of Anatomy, Middlesex Hospital; Hunterian Professor Royal College of Surgeons, etc. Arthrology (Joints); by the editor, Henry Morris, F. R. C. S. Myology (Muscles); by J. H. Davies-Colley, F. R. C. S., Surgeon to, and Lecturer on Surgery (late Lecturer on Anatomy), Guy's Hospital, etc. Blood Vessels and Lymphatics; by W. J. Walsham, F.R.C.S., Author of "Manual of Practical Surgery," Assistant Surgeon to, and Lecturer on Anatomy at, St. Bartholomew's Hospital. Nervous System; by H. St. John Brooks, M. D., of Dublin, Chief Demonstrator of Anatomy, University of Dublin. Eye; by R. Marcus Gunn, F. R. C. S., Surgeon to Royal London and to the Western Ophthalmological Hospitals, Surgeon to Great Northern Central Hospital, etc. Tongue, Nose, Ear, Heart, Voice, Respiration; by Arthur Hensman, F. R. C. S., Aural Surgeon (late Senior Demonstrator of Anatomy) Middlesex Hospital. Organs of Digestion; by Frederick Treves, F. R. C. S., Surgeon and Lecturer on Anatomy, London Hospital, etc. Urinary and Generative Organs; by William Anderson, F.R.C.S., Professor of Surgery and Pathology, Royal College Surgeons, etc. Surgical and Topographical Anatomy; by W. H. A. Jacobson, F. R. C. S., Lecturer on Anatomy, Guy's Hospital Medical School.

We have examined this volume with great interest. It is of very convenient size, not too large and not too thick for comfort, and the type is clear and sufficiently large. The illustrations are exceedingly handsome. We have not had leisure to compare its anatomical statements with those of other authors, but have no doubt that is has a great future before it as a standard work. We recommend it to the careful consideration of everyone who is thinking of purchasing a complete yet handy anatomy.

Books and Pamphlets Received.

Fixation after Excision of the Knee; by H. Augustus Wilson, M. D., Clinical Professor of Orthopedic Surgery, Jefferson Medical College, etc. Extracted from *American Journal Medical Sciences,* March, 1893.

New York Eye and Ear Infirmary Reports, Vol. 1, *Part* 1, January, 1893. This handsome new journal will appear occasionally as material shall be collected. It is published by G. P. Putnam's Sons, the Knickerbocker Press, 27 and 29 West 23rd St., New York. Price $1.25 per copy.

Transactions of the Medical Society of Virginia; 23rd Session, held at Alleghany Springs, containing, in addition to many interesting papers, the report of the Medical Examining Board of Virginia, and the names and addresses of the members of the Board.

United States Quarantine Laws and Regulations; February 24, 1893. Treasury Department, Washington. Government Printing Office, 1893.

Involution Form of the Tubercle Bacillus and the Effect of Subcutaneous Injections of Organic Substances on Inflammations; by Samuel G. Dixon, M. D. Reprint from *Proceedings of Academy of Natural Sciences of Philadelphia,* February 21, 1893.

Possibility of Establishing Tolerance for the Tubercle Bacillus; by Samuel G. Dixon, M. D., Professor of Hygiene, University of Pennsylvania. Reprint from *Medical News,* October 19, 1889.

An Outline of the Technique of Abdominal and Pelvic Operations as Performed in the Medico-Chirurgical Hospital of Philadelphia; by Wm. Easterly Ashton, M.D., Professor of Gynæcology in the Medico-Chirurgical College. Reprint from the *Medical Bulletin,* January, 1893.

The Weekly Review, an illustrated magazine published in Boston at 5 Somerset St., by J. Morrison Fuller.

Our Dumb Animals, Volume 25, No. 9, February, 1893. Published at the Goddard Building, 19 Milk Street, Boston, Mass. An interesting paper issued under the auspices of the "Massachusetts Society for the Prevention of Cruelty to Animals," the "American Humane Education Society," and the "American Band of Mercy," and devoted to the furtherance of the objects of these societies.

Diseases of the Skin, a Manual for Students and Practitioners; by Charles C. Ransom, M. D., Assistant Dermatologist, Vanderbilt Clinic, New York. (Students' Quiz Series.) Edited by Bern B. Gallaudet, M. D. Philadelphia: Lea Brothers & Co., 1893.

Proceedings of Philadelphia County Medical Society, Volume XIII, Session of 1892; Lewis H. Adler, Jr., M. D., Editor, Philadelphia. Edited for the Society, 1892.

Our readers will be ready to appreciate the collected papers of this eminent society, since many of them have appeared separately during the year in our original article columns, and have been received with warmest praise as the productions of leading medical workers and thinkers of the day.

Medical Progress.

TREATMENT OF EPILEPSY BY ŒNANTHE CROCATA.

The article which appeared in your valuable journal of January, 1893, entitled "Note on the Treatment of Epilepsy by Acetanilid," brings to my mind the history and treatment of two cases of epilepsy, and a partial history of a third case, the last named of which I know nothing at present. The treatment of these cases was by the administration of œnanthe crocata. Œnanthe crocata is said to be a remedy for mal-nutrition and anæmia of the brain and spinal cord. Unfortunately I can find but little literature on its physiological and therapeutic action. But despite this fact, in has proven a valuable remedy in my hands, beneficial in these cases, and I report them for the careful consideration of the readers of the *Review*.

Mrs. R., aged 42, mother of three children, for years had been subject to frequent attacks of grand mal. During the treatment given by her physician, about four years ago, it was deemed wise to remove her ovaries with a view of relieving her attacks of epilepsy. Ovariotomy was performed by one of the most skilled ovariotomists of Philadelphia, but her attacks were just as frequent, appearing once a week or oftener. When I was called to see her, in March, 1892, she was lying in bed in a perfectly unconscious state, which lasted for over two hours. Knowing that she had been treated by various physicians, I ordered œnanthe crocata to be given as soon as she regained consciousness. The treatment was continued two months, during which time she had but one attack. I then ordered the treatment to be alternated with a rest of two weeks and then resumed, since which time she has had but two attacks.

Marie R., aged 3, during babyhood and early childhood was subject to attacks of grand mal, both night and day, and at very frequent intervals. I gave her the various remedies advised, but all to no avail. Her parents tried other physicians and even took the child to Father Mollinger, who prescribed with no result. Her mother at last came to me and asked if something could not be done, as she was having attacks daily. I then ordered œnanthe crocata, and was pleased to hear at the end of a week that the attacks were less frequent, and at the end of a month had entirely disappeared. She has been taking the remedy ever since, alternating with periods of absolutely no medicine whatsoever, and has had no attack.

The third case was given œnanthe crocata, and was entirely free from attacks so long as he continued its use. He then entered a business which shattered his mind, and the attacks returned. I do not now know his condition.

I am fully persuaded that œnanthe crocata given to epileptics and persisted in will do far more towards relieving the disease than bromides, chloral, ergot, acetanilid and the many other drugs that have been given. I think that œnanthe crocata, like all remedies given, must be persisted in and continued for a long period, and then given at regular intervals indefinitely. I regret that I cannot give more concerning the physiological action, but as its literature is so scarce I cannot.

Adults can take five drops four times a day. The child was given two drops three times.—Dr. Zimmerman, *Pittsburgh Medical Review*.

SYMPHYSIOTOMY.

From an instructive lecture on this subject by Professor Pinard, of Paris (*Lancet*, Feb. 18), we extract some paragraphs, omitting for want of space the

details of cases. He says: The moment has come for us to draw up our balance-sheet and see what exactly has happened as regards symphysiotomy at the Clinique Bandelocque during the year 1892. First, it is with a satisfaction I do not attempt to conceal that I am able to say that in 1800 cases of delivery during the year I have not once had to practise embryotomy on a living fœtus. Still, we have had to struggle with a considerable number of cases of contracted pelvis. In all the cases we have only performed conservative operations. I only wish to speak to-day, however, of the cases of symphysiotomy, to show them to you and to let you appreciate the results. Thirteen symphysiotomies have been practised in the Clinique Bandelocque during 1892—eight by myself, the rest by my assistants. I did the first on February 4; the last was done on November 14th. I will show you the thirteen women, for they have been very willing to come back to-day. In this way you may judge of the immediate and subsequent results of symphysiotomy. I will present them in chronological order, giving with each a short *resume* of the notes of the case. (Cases omitted.)

THE OPERATION.

All antiseptic precautions having been taken and the surgical and obstetrical instruments prepared, the woman should be placed on her back near the side of a firm bed of moderate height, so that one may command directly from above the median line, which has to be incised. In the case of the cadaver, one can stand on the right side to perform symphysiotomy. On the living it is better, on account of the development of the abdomen, to stand between the limbs. I have always done so on the living. An incision should be made in the median line, and exactly in this line, of the integuments and the prepubic adipose tissue for an extent of about 8 cm., the incision stopping above the clitoris. The rect in the upper part of the incision and immediately above the symphysis should be separated in order to allow the index-finger to penetrate into the prevesical cavity and protect the bladder. This finger plays a most important *role* for me; it protects, it gives information. It protects the bladder by its dorsal aspect; it often feels the pad of the symphysis (but not always, for this is often so very slightly prominent that it cannot be appreciated) and thus renders the section easy. As soon as the bistoury has penetrated into the symphysis it is this finger on which its blunt point strikes, and that keeps a record of its progress down to the last fibres of the subpubic ligament. The finger being thus in the pre-vesical cavity, the symphysis must be incised from above downwards, and from before backwards, by many touches of the bistoury, allowing the latter to penetrate where it finds least resistance. As soon as we are within the symphysis the bistoury must be allowed to guide, so to speak, and not be compelled to follow a straight line. Immediately after cutting the symphysis a complete section of the subpubic ligament should be made. For this section the precaution must be taken of introducing a sound into the urethra so as to incline the latter down to the side; then the ligament must be attacked with caution by small cuts, as if cutting it fibre by fibre. The finger shows the progress accomplished; and as a general rule, when the finger learns that only a few fibres remain, like a small resisting cord, this cord breaks and the spontaneous separation, which had been only a few millimeters, suddenly increases and reaches two or three centimeters. A careful abduction of the thighs then shows that a further separation can be easily obtained. I cannot too often repeat that before all obstetrical attempts one must be sure that the section is complete so that the fœtus may have nothing to overcome by violence and at the peril of its life—that is to say, the pubes must be separated for

at least four centimeters. If the abduction of the thighs is not sufficient to produce this separation, the registering separator, which has been made for us by M. Collin and which I show you, introduced between the two surfaces of the section, will easily produce this desirable and indispensable result. This being done, the wound must be closed with a sponge and antiseptic gauze or wool. You see that I reject, completely and absolutely, subcutaneous section, the incision of the symphysis from below upwards and the incision from behind forwards. You observe especially that I am in complete opposition to those who advocate incomplete section or who leave the subpubic ligament. I am convinced that if I had obtained a preliminary separation of four cm. in my first operation before extracting the fœtus instead of leaving to the after-coming head the duty of separator I should have obtained a better result. So much for the method of operation in symphysiotomy itself.

THE DELIVERY.

I now examine an obstetrical question and say that both before and after symphysiotomy it is preferable to have a vertex presentation. An application of forceps is better than an extraction by the feet; at least, so I think. But, here, again, I cannot too often repeat that the application of forceps ought to be exact. The hand should be thoroughly introduced so as to place the first blade in the middle of the pre-auricular region; if the head is not flexed it should be first flexed with the hand. Nothing is easier. That being done, the other blade should be introduced without displacing either the first blade or the head. Remember that when the two blades are introduced and placed, if they are not on the same plane and if you are obliged to make an effort to articulate them, the blades are badly placed, the head is wrongly seized, and soon in pulling you will, without doubt, make the head endure enormous local pressure and produce fractures. The necessity for an equal application of forceps on a flexed head after as well as before symphysiotomy is absolute. Then after section of the symphysis I prefer to intervene and not to trust to uterine contractions alone to expel the fœtus; also, after the extraction of the fœtus, I do not prolong the period of delivery. If after a quarter of an hour the placenta is not detached I practise artificial delivery; for the patient under the influence of chloroform is liable to hæmorrhage and the anæsthesia must be continued until the sutures are completed. Immediately after the delivery I advise you to wash out the uterus. When the water returns clear and the uterus is well retracted I introduce into the vagina iodoform gauze, then I clean the wound with a sponge and a five per cent. carbolic lotion and proceed to suture the soft parts. The symphyses being brought together and well in contact, I place four deep silver sutures (which touch the anterior surface of the pubis) and four superficial ones, and then cover with iodoform and iodoform gauze. After this, the legs being brought together and held in position by a bandage, the woman is placed in a bed which I have had made —a bed which, by means of its two lateral and concave tampons, enables the pelvic bones to be kept in constant apposition. The superiority for this purpose of my bed or of the "Gouttière de Bonnet" over the simple apposition of the legs with a well-applied trunk bandage very firm in the pelvic region, or a plaster bandage, consists in the facility with which the whole body may be raised without causing the least movement of the pelvis. The sutures are removed on the eighth day. The patients may rise on the twentieth day. For the open section of the symphysis from above down and from before back (the French method), one needs only a short-bladed, strong bistoury and a probe-pointed bistoury. But a chain-saw and a registering separator may be useful.

QUARANTINE IN THE CHESAPEAKE.

The daily papers inform us that Surgeon-General Wyman has obtained from the fund for the establishment of quarantine stations an appropriation of $40,000 with which to establish the new station for Baltimore-bound vessels on Hog Island, in the Chesapeake bay. A board has been appointed to make a preliminary survey of the island and the adjacent waters, and will begin its work at once. The work of building a pier and of erecting the necessary disinfecting apparatus and buildings on the island will be pushed forward as rapidly as possible.

Deputy Collector John R. King, representing Collector Marine, of Baltimore, called at the Treasury Department at once and had a conference with O. L. Spaulding, assistant secretary, and Surgeon-General Wyman in regard to quarantine regulations and the entry of steamships carrying immigrants. The authorities at Baltimore were in doubt as to whether the President's proclamation of September, imposing a twenty days' quarantine on vessels bringing immigrant passengers to this country, was annulled by the act of February 15, 1893. Mr. King informed the treasury officials that the steamship people of Baltimore felt that they had been discriminated against during the past six months. He was told that the collector at Baltimore would receive instructions similar to those sent to New York, which were that vessels arriving at that port having immigrants on board and having a certificate from the local health authorities should be admitted to entry.

TREATMENT OF RECTAL ULCER.

Dr. H. M. Brown, of Hillsboro, Ohio, writes as follows to the *Cincinnati Lancet-Clinic:* For years and years I have treated indolent ulcers of the rectum with all kinds of hard and fast methods with—on the whole—unsatisfactory results. Recently, having become much exasperated with a case of long standing, I resolved to try a new method, at least new to me, and was surprised when I found that I had cured my patient in about three weeks.

The following is the method: In 1879 Hilton published a book which he called "Rest and Pain." In that book he recommended, for the treatment of indolent ulcers of the leg, a deep incision carried around the whole circumference of the ulcer, just outside its margin, the incision to be packed with cotton or gauze and dressed aseptically. The packing being an effectual obstruction to the hyper blood-supply to the ulcer, it heals, or rather dries up for want of nourishment.

Having treated several cases, after that plan, very successfully, I was induced to hazard the same procedure in a case of rectal ulcer. Accordingly, the patient was put under ether, and the rectum well dilated with a Pratt's dilator. The point of a curved knife was carried well down through the entire rectal wall and made to complete the whole circle of the ulcer just outside its ragged edges. No packing was introduced, but after sponging the incision as dry as possible with a twenty per cent., solution of cocaine (the latter being used for its astringent effect), it was cauterized full to the bottom with pure nitric acid and left to heal. Being so astonished myself to see such prompt relief, I think it worth reporting.

PROLONGED MEDICAL EDUCATION.

In commenting upon the Annual Report of Harvard College, the editor of the *Boston Medical and Surgical Journal* says: Dr. J. S. Billings, in a recent article on "Medicine as a Career," arranges the preparatory years of one who would fit himself for the medical life, as follows: "My young friend whose attention I

wish to direct to medicine as a career will have spent five years at a good intermediate school as a preliminary to entering the university, which he does when he is about seventeen years old; will have spent three or four years at the university, four years at the medical school, one and one-half years in the hospital, and two years in travel and special studies. When, therefore, he is ready to begin work he will be about twenty-eight years old, and his education, living, books, etc., will have cost about eight thousand dollars from the time he entered the university. It can be done for less, but this is a fair average estimate."

If this imaginary young friend went to Harvard, he would be more nearly nineteen than seventeen on entering the undergraduate department; he would be about twenty-three on entering the medical school with an A. B. degree; he would be twenty-seven when he secured his M. D. degree; and if he spent eighteen months in a hospital and two years in travel and special studies, he would be fully thirty years of age when ready to begin the practice of an arduous profession, the first years of which are apt to be years of patient drudgery. For turning such years to profitable account, the hopefulness, the enthusiasm, the elasticity of youth are most essential. But at the age of thirty, for most men, the sun is already high above the horizon, the dew is off the grass, and the first freshness has gone from the morning air.

Dr. Billing's programme is a little too elaborate for the average medical aspirant, for whom it is hardly meant; but if this is true, in a still greater degree is it true that the double Harvard degrees (A. B. and M. D.) with their present requirements, are luxuries suited for a small number of exceptionally placed men.

PREVENTION OF SORE NIPPLES.

We have been told by many that it is well to look after the nipples and breasts, especially of primiparæ, for some time before the advent of labor, and employ applications of astringent and spirit lotions for the purpose of hardening the nipples. Herman says, "This often prevents sore nipples." I simply mention such meddlesome methods in order that I may condemn them in the most emphatic fashion possible. I believe that nipples "hardened" in any such way are much more apt to crack and become "sore" than those that are severely left alone.

I shall not refer to the thousand and one remedies for sore nipples. Among the many good ones at hand, each practitioner is apt to choose his favorite. For some years I have used what I consider to be the best application I have ever seen, and which was first recommended, so far as I know, by Hirst, of Philadelphia, viz.:

Castor oil, Subnitrate of bismuth,	Equal parts.

I have applied this in all cases as soon as there is the slightest suspicion of tenderness in the nipples. It is, of course, perfectly bland and safe for both mother and babe, and it is not necessary to wash the nipples before the child is applied to the breast. If you desire to have a woman amuse herself for a few weeks before labor by manipulating her nipples, it is far safer to place this combination in her hands than astringent and spirit lotions. If the castor oil and bismuth fail to give relief, I use a nipple shield. I will not recommend any particular form of shield, but I generally prefer one with a broad base and a dome which will not press on the nipple.—Dr. Wright, *Canadian Practitioner*, February, 1893.

TIN POISONING.

Summing up his conclusions at the end of an interesting article upon this subject (*Therapeutic Gazette, March* 15), Dr. Campbell says:

As a therapeutic agent, tin is obsolete. Stanni pulvis was an officinal preparation in the U. S. Pharmacopœia prior to 1850. It was classified as an anthelmintic, and was thought to act in a mechanical manner.

From the study of these cases I would come to the following conclusions:

1. Stannous salts are poisonous to the human system, being similar in their actions to the other mineral posions,—lead, zinc, arsenic, antimony, etc.

2. The salts of tin are anthelmintic as well as the powdered product.

3. Toxic doses of the salts produce symptoms similar to those from ptomaïnes.

4. Canned-food products may contain stannous salts in poisonous quantities.

5. The danger from this source is increased from exposure to the air; hence all fruits should be emptied from tin cans as soon as opened.

TREATMENT OF SCIATICA.

In a recent address, Dr. Weir Mitchell said: (*Medical Record,* December 24):

My remarks in regard to neuritis lead me to say a few words about sciatica, which is nearly always some grade of neuritis. At least twenty years ago I began to treat such sciatica by local splint rest with from two to three weeks of local use of ice, if rest alone failed me. Although I have over and over called attention to these means, they have not so captured professional confidence as I could desire. Last year I wrote on them a lecture in the International Series, where it is, I fear, pretty well buried amidst some good, and some poor, clinical lectures. As I have of late modified the treatment, and am sure from my own experience and that of Professor Osler, Dr. Sinkler, and others, of its great value, I beg to ask you to consider it with me anew. In any obstinate sciatica, where I can exclude spinal cord disease, constitutional states, tumors, etc., I put my case in bed. Then I give cod-liver oil, iron at need, full diet, and milk between meals. A long flannel bandage is put on at once rather tightly from the foot to the groin, and renewed twice a day. At the side of the limb a long splint is secured by a few turns of bandage. The splint should reach from axilla to ankle, the knee being bent a little, the heel secured from pressure. The splint and bandage are kept in place two to four weeks, night and day; daily, when these are removed, the leg is slowly and very moderately flexed and extended. The treatment is in constant use at the Infirmary for Nervous Disease. If it fails, it is usually because the malady is at first, or has become, spinal. The rationale of its use is, I think, clear: 1. The flannel bandage lessens the blood in the leg. 2. It protects the whole skin surface from the excitation of contacts. 3. The enforced immobility makes all motion impossible, and so the two uses of the nerve cease. It is in splint and we get physiological rest. Since I have used the bandage the cumbersome use of ice along the nerve track is less often required. At the close of the treatment, massage, used with extreme care, may hurry the recovery.—*College and Clinical Record.*

TREATMENT OF GONORRHŒA.

Number of cases of acute gonorrhœa treated by injections at a comparatively early period of the disease, 150; uncomplicated with posterior urethritis or epididymitis, 85; developing posterior urethritis, 52; developing epididymitis, 13.

Acute gonorrhœa treated without injections till the subsidiary stage was well developed, 150; uncomplicated with posterior urethritis or epididymitis, 134; developing posterior urethritis; 12; developing epididymitis; 4.

After a comparison of the results obtained by these two methods of treatment

it would seem that there is but one conclusion to be drawn—namely, that the use of injections, prior to the subsiding stage of acute gonrrrhœa, acts, in quite a large proportion of the cases, as an exciting cause in the production of posterior urethritis and epididymitis, and on this account is not to be considered as the best treatment of the disease.

All patients at the venereal dispensary of the University Hospital are now put upon the internal use of a capsule, made bv Parke, Davis & Co., containing five (5) drops of oil sandalwood and five drops of oil of copaiba, with one drop of oil of cinnamon. From four to eight of these are taken daily for the first three weeks.

When the "morning drop" persists, an injection of sulphocarbolate of zinc and hydrastis is used.

It is not claimed for this plan of treatment that it in any way cuts short the duration of the disease, but only that it aids in preventing the frequent occurence of posterior urethritis and epididymitis, the two most troublesome complications of gonorrhœa.—Dr. Christian, *Therapeutic Gazette*, March 15.

HEALTH CONFERENCE.

A communication to the daily press from Washington, D. C., says: A conference of maritime quarantine officers and officers of the marine hospital service convened, March 14, at the office of Supervising Surgeon-General Wyman, of the marine hospital service. The object of the conference is to secure the co-operation of the State and local maritime quarantine officers in the adoption of a set of uniform quarantine regulations in order that along the entire coast there may be concert and uniformity of quarantine during the coming summer, when cholera may visit the country. When these regulations are agreed upon, Dr. Wyman will ask the Treasury Department to sanction and promulgate them.

Those present from outside of the city were Dr. Samuel Durgin, Port Physician of Boston; Dr. Frank W. Wright, Health Officer of New Haven, Conn; Dr. A. Clark Hunt, representing the State Board of Health of New Jersey; Dr. Benjamin Lee, Secretary of the State Board of Health of Pennsylvania; Moses Veale, Health Officer at Philadelphia; Dr. James F. McShane, Commissioner of Health at Baltimore, Md.; Dr. Wm. A. Thom, Quarantine Officer at Norfolk, Va.; Dr. H. B. Horlbeck, Health Officer at Charleston, S. C.; Dr. W. H. Brunner, Health Officer at Savannah, Ga.; Dr. S. R. Oliphant, President Board of Health of Louisiana, and Dr. R. M. Swearingen, State Health Officer of Texas; Drs. J. V. Porter, Health Officer of Florida; Willard Springer, Port Physician of Wilmington, Del., and W. C. Curtis, Quarantine Officer at Wilmington (N. C.), quarantine.

Dr. Jenkins, quarantine officer at New York, telegraphed that he had been detained by reason of a vist to Albany, but would arrive later.

Officers in other Atlantic and Gulf Coast States accepted the invitation to be present.

WATCH YOUR DRUGS.

In closing an article on "Drugs used in nervous disorders," Dr. Boyer (*Jour. Nerv. and Ment. Dis.*, Feb.), says:

It is quite natural that the man in whose hands a new drug has given satisfactory results should be the one who makes a report of the drug. Successes are easy to report. But the man who fails in his efforts does not, as a rule, rush into print with them, and much valuable information in regard to the therapeutic effects of the drug is lost. In the second place, when a physician prescribes

a drug for a malady, his attention is directed so much to the effect of the drug on the disease itself, that the other systemic effects are apt to be disregarded, unless they assume alarming proportions. The reports based on such therapeutic experiments are consequently one-sided, and statements of the innocuous properties of the drug in question are not well founded.

Daily contact with patients who have taken these drugs for varying periods of time has forced upon me conclusions that go far from supporting the opinions commonly expressed. This is so true that a large number of patients who present themselves for treatment will be found to be suffering as much from the drugs they have been taking as from the original disorder, and an absolute removal of all drugs will serve not only to elucidate the condition, but frequently also to give much relief to the sufferer.

Sufficient has been said, however, to raise a suggestion that drugs which produce marked effects in functional nervous disorders are themselves subject to suspicion and should be studied with as much care as there is of eagerness displayed in effecting a cure of the disease.

CODEINE.

Writing at length in the *Cleveland Medical Gazette,* March, Dr. Wolfenstein speaks thus of this useful drug:

Codeine has so many valuable qualities that I feel it ought to be used more universally than it is at present. It is true, it is rather expensive, since it requires three times the dose of morphine to give a similar result; at the same time a given quantity of codeine costs twice the amount of the same quantity of morphine. Still it acts so much more pleasantly than morphine, it does not constipate, it rarely or never disturbs the alimentary tract, leaves no disagreeable after-effects, is really an expectorant, and what is more, it can be taken for months without necessitating an increase of dose to give the required results; taking all this into consideration it can be recommended as a substitute for morphine in almost all cases. Especially in relieving pain, irritation and cough in the affections of the respiratory apparatus in adults and children, both in acute and chronic diseases, and also as a substitute for other opium preparations in subduing pain in chronic, inoperable and incurable diseases—and in these latter cases particularly, since it requires no increase in dosage, even if used for a long time.

Recommendations of Therapeutic Agents.

PAPOID IN DYSPEPTIC STATES.

Dr. Woodbury (*Medical Standard,* Vol. XII), has given an extended analysis of the physiological action of carica papaya. To his results certain cases recently coming under my observation lend clinical corroboration. It has been of especial value in all states where the digestive functions are feeble, inoperative, and seriously impaired from catarrhal complications, or from any other cause, since it is most emphatically indicated when the digestive fluids are unequal to the task of converting the ingesta to a condition preparatory to assimilation.

Case I. Young lady, æt. 19. Symptoms: The patient was pale, lanquid, and debilitated; loss of appetite; pulse feeble, compressible, and small in volume; troubled with insomnia, and extremely nervous. The food that she took was not digested—it was simply decomposed, attended by persistent and annoying eructations of gas, acid in character; she complained of a great pain in her head,

distress after meals, constipation, and irregular menses. I prescribed the following.

℞.—Mass. hydrarg. . . gr. xii
Ex. colocynth, co . . gr. vi
Ex. belladon. . . . gr. iii
Ex. hyoscyamus . . gr. xii
Podophyllin . . . gr. ii

M. ft. et div. in pil. No. xii. S.: One at bedtime.

Having relieved the constipation, I prescribed papoid, bismuth and strychnine as follows:

℞.—Papoid . . . gr. xv
Bismuth subnit. . . . gr. xxx
Strychnin. . . . gr. $\frac{1}{12}$

M. Div. in ch. No. x. S.: Take one powder before breakfast and one before dinner. The first powder to be preceded by a coffeecupful of hot water, taken as hot as it can be borne.

This case represents a very numerous class, which are exceedingly common, instantly recognized, and are successfully treated when papoid is the remedial agent used. In one week this patient reported herself immensely relieved. She said that after the second day the eructations ceased, the acid condition was changed, the distress in her stomach was relieved, the sensation of fulness in her throat disappeared, her appetite improved, the insomnia gave way to restful sleep, and, to use her own forcible phrase, she "had escaped from the horrors of dyspepsia and the intensified horrors of insomnia."

Case II. A gentleman of 35—a remarkably active, clear, intellectual man of tireless energy, and a great sufferer from nasal catarrh, which he had had for fifteen years; it had utterly destroyed the sense of smell; the olfactory had ceased to respond to any appeal, and the catarrhal condition had extended to the stomach and duodenum. He complained of complete loss of appetite, pain in the head, with a furred tongue, constipation, sleepless nights, aversion to exercise, owing to his physical prostration, and a general feeling of fatigue. He had considerable palpitation of the heart, and was deeply imbued with a perpetual apprehension of the recent discovery of heart failure, from which he expected to die at any moment. Having allayed his fears of heart failure, and convinced him that his palpitation was directly attributable to indigestion, I ordered him to take a coffeecupful of water as hot as he could sip it, half an hour before breakfast, and then take one pill ten minutes before.

℞.—Papoid . . . ʒ i
Podophyllin . . gr. ii
Hydrastin . . . gr. ii
Ex. hyoscyamus . . . ♑ i

M. ft. et div. in pil. No. xx. S.: Take one pill before each meal.

In addition, I prescribed hydrastin and eucalyptus an hour after each meal, and a laxative at bedtime. The hot water was continued for ten days; then I abandoned it, and placed him upon—

℞.—Papoid. . . . gr. xxiv
Sod. bi-carb. . . . . ʒss
Bismuth subnit. . . . ʒss
Elix. aromat. . . . f ʒ i
Aq. menth. p., q. s. ad. . f ʒ ii

M. S.: Shake the bottle and give a teaspoonful before each meal.

The catarrhal condition of his stomach, nasal passages and upper bowels proved a most formidable obstacle, and sustained a set of symptoms very obstinate to combat.

He had devoted several weeks, under the professional care of an excellent specialist in laryngology, to the treatment of his catarrh—spraying and insufflation, etc.—which only afforded him temporary relief in this humid atmosphere and changing temperature. I ordered him to continue my course of treatment for six weeks, which he did, during my absence from the city. Upon my return he presented himself at my office, and reported such a radical change in his symptoms towards complete restoration of his health—which his appearance fully sustained and vindicated—that the same line of medication was adhered to for a short time longer, and, within two months from the commencement of his case, he was discharged cured.

It must be remembered that he had been treated by several excellent physicians, who had in every way met every indication and symptom that presented in his case with a host of remedies—scientifically and intelligently prescribed—aided by a long list of dietary articles of the very best quality—peptinoids, pepsin, pancreatin, beef extracts, maltine with its numerous and valuable additions. He had tried the grape cure, the skimmed-milk delusion, and various other good remedies for certain conditions. Within a week from commencing the administration of the wonderful remedy his symptoms changed. His headache left him; the great distress in his stomach, which tortured him for hours after meals, ceased; his tongue became perfectly clean, bowels regular, appetite excellent, complexion clear, spirits revived, and a general appearance of returning health and rejoicing.

The ruling remedy in this case was the papoid ; he having been carefully and scientifically treated for months upon the old plan of remedial agents that I have named without any perceptible relief, and changing directly to a new course of treatment, in which papoid was the chief factor, there is but one logical conclusion to arrive at as to the remedy that wrought the change.

Case III. This patient, who had complained for several years of catarrh of the bladder, following an aggravated attack of cystitis, applied to me for advice and treatment for his urinary difficulties, which he stated were constant, painful, annoying and aggravating to the last degree of endurance.

He had traveled extensively in Europe, spent several seasons at Wiesbaden, and had tried the waters at several health resorts in Germany, returning home without much improvement except of a transient character.

As the patient was over 70 years old, and greatly broken in health, I was not at all sanguine of affording him much relief, and not anxious to undertake the case, which I fully explained to him. That his age and the many years of his physical martyrdom were decidedly against his recovery, all of which he at once conceded, and stated that he only expected and only sought temporary relief. His array of symptoms were truly formidable. He was suffering from dyspepsia, with a full train of attendant manifestations; was in constant dread of heart failure, pain in epigastric regions after taking the slightest nourishment, and complained of acrid eructations and throwing off gas from the stomach; was much troubled with palpitation of the heart, with an intermittent pulse—with a feeling of general surrender to the persistent invasion of disease.

His vesical catarrh was a prominent feature in the multiplicity of his murmurings, and his chamber more than established the fidelity of his painful recitals.

I prescribed the following treatment for him to relieve his costive habit and to arouse his inactive and torpid liver and secretions. I ordered:

℞.—Mass. hydrarg. . . gr. xxiv
Ex. colocynth, co. . . gr. xii
Podophyllin . . . gr. iv
Leptandrin . . . gr. vi
Ex. hyoscyamus . . gr. xxiv
Ex. belladonna . . . gr. vi
Ex. nux vomica . . gr. vi

M. ft. et div. in pil. No. xxiv. S.: Take one pill at bedtime.

After five days I commenced the following plan: I washed his bladder out three times a week; first with equal parts of milk and water, pretty warm, then with boric acid, and lastly with hydrastin and papoid.

I then gave him papoid in combination with soda bicarb. and bismuth, and ordered him to take six ounces of water as hot as he could every morning, with ten grains of sodium chloride, and to take the papoid mixture in the middle of his meals; and once a week he was subjected to vigorous massage by a strong and healthy operator.

I regulated his diet to conform to the indications of treatment. In six weeks he had gained five pounds in weight; the mucus that formerly threatened supremacy in his chamber had almost disappeared. His indigestion was immensely improved, his appetite had returned, and to use his own words: "That papoid is surely the long-sought rejuvenating elixir of youth." I gave papoid the credit, because he had traveled the old line of treatment through many years of patient, persevering and unfailing faith, suffering the pains and penalties attending misdirected effort and stubborn adherence to remedies which have survived scientific application. When the secretions of the stomach are in perfect accord with those remedies the results are quite satisfactory, but administration of pancreatin, pepsin and pepsin mixtures indiscriminately, without regard to the condition of the stomach, is a blind and empirical method of meeting the abnormal condition presented.—A. J. Park, M. D., Chicago.

Medical Items.

At a recent meeting of the Austrian Parliament the Minister of Public Instruction promised that the erection of the new Physiological Institute and of the new Surgical Clinic of Professor Billroth would soon be commenced.—*Ex.*

Eleven towns in England have medical men for mayors. This looks as if the medical men of England take more interest in good government than do their American brethren. We feel certain that they are good officials.—*Cin. Lancet-Clinic.*

We are in receipt of a very beautifully executed invitation, issued by the "Columbian Class" of the Baltimore Medical College, to its graduation exercises, which will be held March 30th, at 8 P. M., in the Academy of Music. The address will be delivered by Hon. John V. L. Findlay.

The next meeting of the Tennessee State Medical Society will be held, as announced, the first Tuesday in April, continuing in session three days. The Secretary writes that he expects to have a splendid meeting, both in point of numbers who will attend and of good papers that will be read. The programme has not yet been sent out, but we shall publish it as soon as issued, so that all will know what good things await them at this meeting.

Woman's Medical College is having a tablet made which will be put in the Maryland Building at the World's Fair. The tablet will be made of composition stone, framed in wood. On it will be inscribed, "Woman's Medical College of Baltimore, incorporated February 24, 1882," and it will also bear the seal of the college. The committee in charge of the tablet is composed of Dr. Amanda Taylor Norris, Dr. Hattie M. First and Dr. Flora Pollack.—*Sun.*

We observe with interest that the Board of Commissioners of Public Schools of Baltimore will open in the early part of April a half-time school in a locality near the business centre of the city. The school will be open for instruction from 8.30 to 11.30 A. M. It is designed for the instruction of those boys whose duties engage their attention at other hours. Parents or guardians who wish to enter their boys into said school are requested to call at the office before April 1, to register the names of said boys.

A correspondent in the *Lancet* reports an interesting case of dumbness with sudden recovery. A gentleman was for four years in a lunatic asylum with the history that he had, without known reason, suddenly stopped speaking. After five years of silence he suddenly began to speak, and explained that having endured his wife's long and unruly tongue for several years after marriage, he had determined not to speak for five years. Englishmen will now probably take some simpler method of domestic discipline.

We have received a circular announcing the Maryland Preparatory School of Medicine of Baltimore City. This seems to be a night school for the quizzing, manikin-training and black-board instruction of the students of our city medical colleges, with occasional lectures by members of the profession eminent in their several branches. There will be a winter and spring session. The instructors are: A. K. Hadel, M. D., University of Maryland, 1143 Park Avenue, Physiology, Pathology and Nervous Diseases, who will furnish further information if desired; E. A. Munoz, Ph. G., M. D., College of Physicians and Surgeons, Practice of Medicine and Materia Medica; J. Wm. Funck, M. D., University of Maryland, Eye and Ear, and Obstetrics; Henry M. Baxley, Ph. G., M. D., Baltimore Medical College, Chemistry, and Diseases of Women and Children; Haughton Baxley, M. D., College of Physicians and Surgeons, Anatomy and Surgery. We will take interest in observing the development of this enterprise.

The Annual Competitive Examination for the positions of interne at the Cook County Hospital, Chicago, one of the largest hospitals in this country, was recently conducted by thirty members of the regular medical staff. An examination of the records shows that of the thirty-one competitors, twelve were students of Rush Medical College, nine of the Northwestern University Medical School (Chicago Medical College), nine of the College of Physicians and Surgeons, and one was of the Northwestern University Woman's Medical School. The eight positions were secured by E. H. Tinen, F. A. McGrew, R. B. Oleson, J. J. Claussen, G. W. Skinner, T. J. Williams, T. P. Findley and T. A. Olney, in the order named. Representatives of Rush Medical College secured 1st, 2nd, 5th, 6th and 8th (five) places; Chicago Medical College, 3rd and 7th (two) places; College of Physicians and Surgeons, 4th (one) place. Interneships in this hospital are among the most valuable positions obtainable in this country and as they are very earnestly competed for by the best students of the different medical schools in that city, the gentlemen securing positions are to be congratulated.

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Original Articles.

THE USE AND ABUSE OF THE DRAINAGE TUBE IN NON-PENETRATING WOUNDS.*

BY ROBERT W. JOHNSON, M. D.,
Professor of Principles and Practice of Surgery, Baltimore Medical College.

When Chassaignac applied the drainage tube to wounds, he made one of those great strides that mark eras in surgery. Not that drainage was unknown prior to his practice, but, like so many famous experimenters, he kept on doing in a rational manner and persistently what others may have done spasmodically and sporadically.

Esmarch's bandage must have been applied by surgeons after Hunter's discovery before the German surgeon made it his own by persisting and insisting on its use, which very proclamation of its virtue gave him letters patent to fame like those which inventors receive.

Now, I do not mean to take up the great subject of drainage in its entirety; and by way of curtailing my remarks will confine myself to a short discussion of the use and abuse of the drainage tube in wounds outside the three great cavities of the body, or, as they are technically called, non-penetrating wounds.

I have said that Chassaignac bestowed a great boon on surgeons of succeeding generations; but *tempora mutantur et nos mutamur in illis.* The conditions of the present are not the same as involved all wounds except subcutaneous ones and a few ac-

*Read before the Baltimore Medical Association, Feb. 27th, 1893.

cidentally clean wounds in Chassaignac's time. They were all with the above exception dirty wounds; and had no progress been made in the last half century, we should have been as dependent on the drainage tube as the contemporaries of the great French surgeon.

For our purpose we must divide wounds into three great classes: (1) infected, (2) suspected, (3) ideal.

1. In the infected we have certain positive indications of pus or other toxic presence and must proceed to eliminate it.

2. In suspected we have reason to doubt the cleanliness of the wound, either from our own faulty technique, or accident over which we have no control; and we must be prepared to drain should the suspected develop into the infected wound. Very often the suspicion is groundless and our wound may be pure as Cæsar's wife; in which case we are called to use judgment as to the propriety of having means of drainage where the wound is thus practically ideal.

3. By ideal, I mean a wound, generally of the surgeon's own making, where every safe-guard for cleanliness has been taken and we can feel, as we look into its recesses, that there is hardly a possibility of contamination.

So much for the casual glance at the kinds of wounds. Now, a word about the means of drainage. First we have the rubber drainage tube and its congeners, the decalcified drain, strands of horsehair, catgut, silk, or whatever is intended to act as a drain through whose lumen or interstices and between whose cords the effused contents of wounds may dribble away.

Second, we have the more subtle action of gauze, whose wick-like structure, together with the capillary attraction of its fibres, not only affords an avenue for escape, but lures secretions from their birth-place.

Finally, there is drainage to be secured by the relaxed suture at the most dependent part of wounds, a sort of safety-valve in case tension becomes irritating, when the pressure may be relieved by oozing of the wound secretions out of the opening left for that purpose, without the mechanical interference of tube or gauze. The salient feature about this last method and one that commends itself to surgeons who do not want more foreign bodies in their wound than they can avoid is the fact that the wound by this method contains no abnormal substance except the ligatures and sutures, which, if properly prepared, do not give trouble, and we have no reason for undressing wounds so treated unless the thermometer indicates infection, or the dressing, dampened by the discharge, becomes foul.

The fact that the dressing is permeated with blood—*provided it dries* before it decomposes, as it will if the dressing be antiseptic as well as surgically clean—is no drawback or indication for change. I have over and over again let amputated stumps, when there was no drainage tube or gauze in them, remain in the dressing originally put on, for ten days or two weeks or until such time as I wanted to examine the sutures. This is the dressing I generally use in ideal, and often in moderately suspected wounds.

The incision is sewed up, except one relaxed suture at most dependent part, taking particular care to approximate the edges of the wound accurately. Iodoform, rubber protective with holes in it, iodoform gauze, mild bichloride gauze or cotton, a lino bandage wrung out of mild bichloride, which will harden as it dries and make graduated compression to obliterate dead spaces, and finally a splint to keep the parts at entire rest. In such a dressing as this the oozing wound secretion, if not too much, will soak, dry, harden and form an impermeable cap to the stump and when removed show you satisfactory union along the whole incision. I have no anxiety, unless my thermometer shows infection, at the appearance of a blood spot on the outside of my dressing. I do not feel that the dressing is therefore necessarily unclean and requires change, unless the temperature indicates that bacteria may have been left or worked their way backward from the surface of the dressing to the wound surface before the blood has dried in the dressing.

Now, a word about the rise of temperature in the first three or four days after an ideal operation. I think the general practitioner over-estimates its importance. Observation has shown that after simple fractures there is a rise of temperature dependent partly on what is known as fibrin ferment in the clot at the point of fracture, and though this may be actually more marked than the rise of temperature after a well-drained compound fracture in the first day or two, the fibrin ferment fever is not to be held as a cause of anxiety, for it quickly subsides and is no excuse for a panicy belief that the wound is infected, due to bad drainage, and that therefore the second operation of redressing must be immediately carried on to rescue the wound from septic infection. Temperature that flares up in the first thirty-six hours, or even later, say three days after an approximately clean wound, much less an ideal one, is not as a rule due to infection by pus organisms, as they have not had a chance to get in their work; but is due to chemical irritants, the products of bruised tissue and extravasated blood, produces but little malaise and is no cause for alarm unless it fails to subside.

In my ideal wounds therefore I do not as a rule use any drain beyond the possible relaxation of a suture in the most dependent part, nor do I hasten to suspect and treat on suspicion my ideal wounds that present a moderate rise of temperature in the first forty-eight hours or three days which I believe due to fibrin ferment and not pus. Again, I do not hasten to remove antiseptic dressings that have been slightly tinged with ideal wound secretions, if I think the antisepsis will check the progress of bacteria inward or, drying, become impermeable to them. Instead of draining pockets I prefer to prevent them by equable compression and subdue irritation by rest in splint. So much in a cursory way for the drainage tube in ideal wounds. I do not use it if I can help it. I do not want the foreign body to irritate—to make me change my dressing again and again, and by setting up as a foreign body a *locus minoris resistentiæ*, a desirable habitat for germs that may be introduced through this means.

Now let us consider the drainage of suspected wounds. In these we have the

element of doubt as to their cleanliness; we may not have had the making of these and we may feel that we can not be sure they are clean. They may or they may not be infected. As they reach toward the border line of purity or infection we may treat them as ideal or infected. I confess a weakness toward considering suspected wounds not quite as bad as they are painted—a sort of reaction against giving a dog a bad name—and trusting to blood clot to maintain my tentative position; but there are between these extremes some whose character we cannot decide on. How shall we drain these wounds suspected to be beyond the salvation of the blood clot?

Instead of the irritating tube, I should suggest the gauze acting as a wick and removing the questionable fluid contents from the interior. I think this drain is less irritating, it is more apt to be clean, it presents pliant edges to the wound surface and is adapted to shape. If there is value in the sieve-like action of cotton put over test tubes to prevent infection from without, may we not have an analogous but not so certain antiseptic sieve (since it is wet) to the wound from outside? It is easy to retain in the wound and is part of our necessary armamentarium. It should be removed as soon as we find our wound is not infected, say in four days, and not replaced necessarily. It should be replaced by the drainage tube if we find suppuration bound to take place, and this leads us to the last division of our subject, the drainage in infected wounds.

It was with these surroundings and these conditions that the drainage tube was conceived and brought forth in pre-aseptic days, and to-day, like many another brilliant offspring of genius, it finds its best place in the surroundings and circumstances for which the parent genius conceived it. Here is the field for the drainage tube, the pus wound; here your blood-clot may be unsatisfactory; here your relaxed suture fails; here your gauze may not do all that is anticipated; but here the drainage tube fills the full measure of your expectations and continues to cast a golden halo born of streptococcus pyogenes aureus over the revered memory of Chassaignac.

In conclusion of this paper, as of any I write, I do not wish to dictate or say "thus far and no farther." Surgery is too progressive for one generation to imagine it made up of a decalogue of "thou shalts" and "thou shalt nots," nor can any man join an antiphonal choir in science and sing only one side. We may progress sometimes by going backward and I would advocate no absolute rules about matters still *sub judice*. I give you the above result of a short experience, hoping it may prove interesting to you, as it has proven satisfactory to myself.

PROTECTION OF CHILDREN IN FRANCE.

The French infant-food bill, which recently has become law, prohibits parents from giving their children under one year of age solid food in any form without the prescription of some physician. The use of bottles with rubber tubes is also forbidden. M. Rouchard, the president of the Society for the Protection of Children, to whose efforts the passing of the above bill is principally due, asserts that out of 250,000 infants annually dying in France 100,000 might be saved by careful nursing.—*Ex.*

Society Reports.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD FEBRUARY 27TH, 1893.

Meeting called to order by President Pennington. Minutes of previous meeting read and approved.

Dr. Geer proposed for membership Dr. J. B. Saunders, Dr. J. D. Farrar and Dr. Adams.

Dr. Johnson read a paper on USE AND ABUSE OF THE DRAINAGE TUBE. (See page 485.)

Dr. Tiffany said: There is little to be added to what Dr. Johnson said; he has taken the right position. I very rarely use it at all; it has almost passed out of my practice. In cases of death of bone I sometimes use it, but very seldom.

It is not my habit to stitch wounds so tight as to cause strangulation of tissue. I never use iodoform gauze, and in reference to outside dressings I will say I am not a believer in iodoform and bichloride gauze; they are apt to get dirty and make an unclean dressing.

I do not use iodoform once in six months, and am not in favor of the use of any chemicals. The odor of iodoform is against it and when I go through a ward and smell it I expect to find tuberculosis.

Dr. Johnson has referred to a primary rise of temperature in many cases. Now I expect to see and do see a rise of temperature even in a simple fracture.

I hope with Dr. Johnson that the drainage tube will be less and less used.

Dr. J. W. Chambers: Dr. Johnson has left nothing to be said. All surgeons have a tendency to drain everything they are in doubt of. I drain when I think the surfaces will not come together or where there is dead bone. In suppurating joints after the operation on bone I often use iodoform gauze.

As to the rise of temperature, I find that to be the case in a passionate man. If you do not want to take a man's word for it, to use the bichloride gauze, you can sterilize it yourself. I make it as I use it, and the wounds do well. Iodoform gauze will irritate the skin.

I am not a surgeon who never sees a drop of pus and it will never amount to anything unless it disturbs the patient; it tends to make us think we have been careless.

Dr. Johnson has alluded to protection dressing. What does it protect? It irritates the wounds, and think it should be done away with. He says he cuts holes in it, and I think that is the only good thing about it. A good thing is to place a man in an air-tight suit. I agree with Dr. Tiffany on what he says of the use of chemicals, and I think they should be done away with. He did not say whether he washed the skin in bichloride or not.

Dr. Johnson: I do not consider it essential to use iodoform, but it may prevent suppuration, and as long as it helps at all I do not think it should be discarded.

My rule is to boil everything except the patient and myself, for we cannot trust to every one as to its having been done. Just as soon as blood oozes through, the wound then becomes infected and makes a perfect channel though which germs can and do go immediately to the wound. Sorry Dr. Chambers had not caught on to the use of protective dressing; he evidently did not understand.

Dr. Crowe read a paper on HISTORY AND TREATMENT OF A UNIQUE CASE OF EPILEPSY.

Dr. Branham asked if the patient had ever fallen and hurt herself.

Dr. Crowe said she had not, but often had bitten her tongue.

Dr. Branham thought it a good diagnostician to differentiate between hysteria and epilepsy; hardly likely painful menstruation should cause epilepsy; patient knowing when an attack was coming on looked very suspicious; the Dr. has said he found a good many blood clots in uterus. If that is so it is very strange the uterus should be so small.

Dr. Gibbon: I do not think you can get good results from 5 or 10 gr. of bromide potash. I think you should give patients all you could short of bromidism. I have a little girl I am giving 12-15 gr. every three hours.

Meeting adjourned.

EDWIN GEER, M.D., Rec. Sec'y.

1534 Park Avenue.

GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

DECEMBER MEETING.

The president, Dr. B. B. Browne, in the chair.

Dr. Hunter Robb read an abstract of an article by Prof. Gusserow on ASCITES IN CONNECTION WITH GYNÆCOLOGY.

In the *Archives of Gynœcology* for 1892, Prof. A. Gusserow, of Berlin, has an interesting article on ASCITES IN CONNECTION WITH GYNÆCOLOGY, of which the following is an abstract:

A high grade of ascites has often been observed occurring in connection with affections of the genital apparatus or of the peritoneum, which seem to occur by preference in women. In these at first even the skilled diagnostician cannot say anything more than that he has a general ascites (non-encapsulated). There is a lack of the symptoms which occur in ordinary ascites; there is no œdema in other parts; for instance, of the legs, the abdominal wall, or of the outer genitals. A patient often comes to us like a skeleton with the exception of a very prominent abdomen, which makes us think at once of an abdominal tumor, in the modern sense of the word, *i. e.*, a new growth. A special characteristic of this kind of case is the absence of all the ordinary factors, one or more of which are so often found to have given rise to ascites. So then, in the first place, a careful examination must be made for disease of (1) the circulatory apparatus, (2) the liver, (3) the kidneys; and only those cases of ascites in which such etiological factors can be positively excluded, come, properly speaking, into the domain of gynæcology; and it is only these and none others that Gusserow is discussing. Most gynæcologists are now agreed upon the best method of handling such cases. Unfortunately the ordinary practitioner is too apt to follow the older method, a circumstance which sometimes proves very unfortunate for the patient. He still clings to the idea that an attempt should be made to ascertain the cause of the ascites by means of a puncture, or what is worse, he is apt to make the treatment consist in further punctures and to continue these till the death of the patient. Puncture is in my opinion in every way inadvisable. It is true that we, in common with other gynæcologists, for many years taught that puncture was always necessary for the diagnosis for an abdominal tumor. This idea they have now given up, and we consider it quite as absurd to make a puncture for diagnosis in the cases of general or "free" ascites. This new doctrine I have taught for years and the same holds good for tapping to take away the greater part of the fluid. It used to be the custom to make puncture with a Pravaz fluid. It used to be the custom to make a puncture with a Pravaz "syringe," and draw off a little

fluid, having it examined chemically and microscopically, in order to make a diagnosis of the kind of ascites and of its probable origin. Although much work has been done on the subject, there are many cases, and especially nearly all of these cases of "general ascites," which we are discussing now, where such an examination will give us no information at all. Better than this is tapping for the removal of the greater part of the fluid, since we thus get a better chance for palpation of the abdominal and pelvic organs, and may possibly be able to detect the cause, which was concealed by the amount of the fluid. This "chance" of making a diagnosis frequently led to the adoption of this treatment, which, as we said, was often not the best for the patient. The reasons against this method are: (1) the uncertainty of being able to make a diagnosis, even when the fluid is drawn off; (2) the faint chance, even with best asepsis at our command, of setting up a septic process; (this latter danger has now, it is true, been reduced to a minimum, but we have nevertheless seen cases of erysipelas and of septic peritonitis from tapping;) (3) the liability of injuring vessels and of consequent internal bleeding; (4) the impossibility of drawing off all the fluid by tapping, and the almost certain return of the fluid, which perhaps will necessitate tapping again and again.

I have given up both the puncture and tapping and prefer to make an incision about 6cm. long, then empty the abdomen of the fluid; and inserting the finger, find out what is the local cause. One is then at once able to decide for or against an immediate or future operation. If a radical operation is not to be done, we have at any rate drawn off all the fluid. The cases are divided into groups. To the first group belong cases of "general" acites as a consequence of so-called "tuberculous" peritonitis. This form appears mostly in young people. No lesion in the heart, kidneys, or liver is demonstrable and no signs of tuberculosis are anywhere found. On laparotomy one finds numerous nodules of a gray, reddish color both on the visceral and parietal surface of the peritoneum. Some of these cases, as it seems to us, are not cases of tuberculous peritonitis in the modern acceptation of the term. We would prefer to call them cases of "peritonitis nodosa." The first case given was observed by me twenty years ago, before the tubercle bacillus was discovered. The patient was quite young, twenty years of age; no signs of phthisis. There was a high grade of ascites. Patient had been tapped several times. Laparotomy preformed, the fluid evacuated and the before-mentioned nodules were found. Seeing the nodules I made a diagnosis of tuberculosis and gave a bad prognosis; and the patient—got well. In the second case laparotomy was performed, the fluid was evacuated and one of the nodules cut out. The central portion of the nodules was caseous, but no giant cells were found. (Tubercle bacilli had not been discovered and were not looked for.) The patient recovered. The third case, which was operated upon in 1892, was somewhat similar. The microscopical examination showed small celled proliferation with a rich blood supply. No giant cells, no tubercle bacilli. In any of these three cases tapping would have been of no avail, for it would not have been possible to make a diagnosis by palpation except by exclusion after the fluid was drawn off, and the diagnosis could only be established by opening the abdomen and cutting out one of the nodules for examination.

The second group consists of cases where the ascites was due to papilloma of the ovaries.

Papilloma of the ovary, or superficial papilloma of the ovary, consists of an abundant growth of connective tissue villi, which comes from the surface of the ovary, while the ovarian stroma itself is either found to be thickened or is nearly

normal. These cases are not always distinguished from those rare cases in which a papilloma has burst, and a part of it has grown free in the abdominal cavity. The characteristics of superficial papilloma of the ovary are, (1) both ovaries are generally involved, (2) they cause a high grade of ascites, which is liable to return again after tapping, (3) they are generally too small to be palpated, even after tapping. The first observation of this kind was published by myself and Eberth in *Virchow's Archiv*, No. 43, 1868. Patient, 34 years of age, had a high grade of ascites for a year and a quarter. Had been tapped several times (in Billroth's clinic among others). No reason for ascites discovered. Umbilical hernia developed and burst, and the patient increased the opening herself and let off the fluid. Finally the hernia became very large. A convolution of intestine had come out through the hernia, and when the patient was seen, most of the small intestine lay outside the abdomen and showed signs of discoloration. Operation for hernia. Rupture of gangrenous portion of intestine; death. Post-mortem showed papilloma of the ovary. (He also adds other cases.) These cases of rare disease of the ovary ought to convince us that where we have ascites from some unknown cause in the abdomen, we ought not to limit ourselves to puncture; in fact, we ought not to puncture at all. In none of them was it possible to diagnosticate the nature of the cause till the abdomen had been opened. In one of them where puncture had been made before, and bloody serous fluid evacuated, we might have been led to think of carcinoma of the peritoneum and been unwilling to operate. This admixture of blood, as a matter of fact, was a result of the puncture. In two of the cases death unfortunately followed the operation, but this must be attributed to the exhaustion of the patient by the frequent tappings. In another case death was caused by septic peritonitis. Otherwise we feel sure that the patient would have been cured, since we have no instance of recurrent papilloma of the ovary where it has once been thoroughly excised.

To the third group belongs those far more common cases of ascites due to carcinoma of the ovaries and the peritoneum. Here it might be asked, "Is not incision necessary? Here we can feel even a nodular tumor after puncture. Is it not sufficient to puncture in order to make the diagnosis?" However, again, we should employ incision. First, because we can never be otherwise sure that the growth is cancerous. Secondly, because only by this means can we decide whether (if there is carcinoma) the ovary or uterus ought to be removed, as it is the rule to extirpate cancerous ovaries unless the peritoneum is involved; and every carcinoma must be removed, if it is in healthy tissue. If there is carcinoma of the ovaries, then by incision we can tell whether or not the peritoneum is affected, and that only can be discovered by laparotomy. It will be objected that in malignant disease laparotomy has sometimes hastened death. This by no means always occurs, and against it we can put, first, the certainty of diagnosis; secondly, if the tumor is benign, a timely operation and recovery; and to these we may add, that where the tumor is malignant, a laparotomy sometimes hinders its progress, and even without futher operation life is prolonged.

These cases fall naturally into three subdivisions: (1) those in which the malignant growth could be removed (with ovaries). It must be remembered that we are not talking now of operations for malignant growths in the abdomen in general, but only of those in which general ascites was the characteristic symptom. Out of three cases two recovered completely, the third died later of multiple sarcomata. In the second subdivision come those cases in which the malignant growths could not be entirely removed. The first case has the following history:

M. G., aged 20, admitted August 18, 1891. Primipara. Three months before entrance she had a great deal of pain in the abdomen, which obliged her to stay in bed. Was in bed for four weeks. Before entrance she noticed a swelling, with no pain, but shortness of breath. The abdomen measured 110 cm. General ascites. No tumor felt by palpation or vaginal examination. Laparotomy, August 19; four to six litres of ascitic fluid removed. Tumor size of fist on right side of uterus in layers of broad ligament. Mass adherent. Removed with difficulty because the tumor was of a friable, medullary material. A great deal of hæmorrhage followed. Left ovary healthy. Diagnosis: spindle and round cell sarcoma. Patient recovered from the operation, but died of peritonitis, without ascites, and of marasmus after seven months. Autopsy, general sarcoma of peritoneum, omentum, retro-peritoneal lymph glands, retro-sternal glands. The next case was one of carcinoma not connected with the genital apparatus, but adherent to the intestines. Removed. Patient left hospital completely well. She was lost sight of.

Of the five cases in this category, in all of which a portion of the growth was left in the abdomen, three died, not in consequence of the operation, but on account of the rapid development of the malignant growths. Two got well (one a woman of 75). What became of these cases ultimately is not known; anyway their lives were prolonged by laparotomy.

To the last subdivision belong those cases of ascites where no attempt was made to remove the tumor, but where the abdominal section was made for the sole purpose of evacuating the fluid; of five cases, two died and three got better for the time being. These cases show that for drawing off the fluid laparotomy is often better than puncture. The fluid can be so much better removed in this way, a diagnosis can be made, and we know with absolute certainty whether an operation is indicated or not.

Lastly, we mention cases of general ascites caused by benign disease of the genital apparatus. The first case was a woman, age 57, nine children; came into the clinic August 4, 1890. Menopause one year ago; since that time had remarked a swelling in the abdomen, which caused her no particular inconvenience. For the last three weeks rapid increase in swelling, causing a feeling of tension, pain in back and abdomen with pain on micturition and prolapsus vaginæ. Abdomen 103 cm. (from ascites). No tumor felt in abdomen, nothing discovered in the other organs. Laparotomy, August 6, 1890. Color of fluid, yellow; hard tumor fastened to left cornu of uterus, easily separated from it. Right kidney a little out of place. The uterus was attached to abdominal wound. Tumor proved to be fibroma ovarii sinistri. Recovery. Vagina replaced. Even operation did not show the reason for so much ascites.

By tapping, of course, we could not have discovered the real nature of the tumor causing the disease. We might indeed have felt the tumor, but could not have told about its malignant or non-malignant character. In another case belonging to this category we could not have any idea of the nature of the disease by tapping. By laparotomy we were able to see plain indications for removal of the tumor, and were consequently able to cure the patient. Professor Gusserow in this article expresses, we think, the views of most of those of us who have had much experience in abdominal surgery. With our present technique, even were the advantages to be gained by such a procedure far less than they really are, we need not hesitate to open the abdomen instead of making a puncture.

When the general practitioner meets with a case of ascites where all implication of the circulatory apparatus, the liver and kidney have once for all been

definitely excluded, it would certainly be well for him to call in the specialist before adopting the "puncture" method. Our own experience fully bears out the futility of attempting to arrive at a certain diagnosis in every case by examination (chemical and microscopical) of the fluid which has been aspirated; the only certain way is to use the hand or the eye, or if possible, both. Again, we have seen more than one case which has come to autopsy where the patient had died after numerous aspirations and where the condition of things had led us to believe that a timely operation might have at least much prolonged the patient's life, even if the disease could not have been thoroughly eradicated. In these cases it seemed that valuable opportunities had been lost, and since an abdominal section not only gives the patient the best chance for complete recovery, but when employed as a palliative measure is more efficient than frequent tappings, it is in almost every case the better method. With respect to the "peritonitis nodosa" of which Gusserow speaks, it does not seem clear to us that these were not instances of peritoneal tuberculosis, and if this were the case the success which attended the operations and which we have seen confirmed in our work would only go still further in proving his proposition.

Finally, in these days when in both medicine and surgery we are all striving as much as possible to avoid working in the dark, and we wish to treat our patients for the disease they really have and not for a hundred and one others which they might possibly be suffering from, the advantages of an absolute diagnosis can hardly be over-rated.

Dr. J. Whitridge Williams: I think we should take the case of Dr. Ashby's as a text to teach us to examine carefully for pelvic growths in all cases of ascites where heart and liver troubles are excluded. If we find ascites associated with a pelvic tumor, the rational treatment is laparotomy and removal of the growth. The operation is very little more dangerous than puncture and is more satisfactory. Ascites is often due to tubercular peritonitis, papillomatous growths on the surface of the ovary, and solid tumors of the ovaries and tubes, both malignant and benign.

Dr. B. B. Browne: These cases recall a case which I saw about three years ago of large accumulation of ascitic fluid in which it was quite impossible to make out any pelvic tumor. Kidney and heart diseases were excluded and the conclusion was come to that the ascites must be due some intra-abdominal growth. An abdominal section was made, and after the evacuation of several gallons of ascitic fluid a papilloma of the ovary was found and removed. I saw the patient about three months ago; she was perfectly well.

Dr. Thomas Opie: I had a case of dropsy associated with large uterine fibroids. I made an abdominal incision with the intention of removing the fibroids, but finding that impracticable, the abdominal cavity was thoroughly sponged out and the wound closed. The patient was very much improved.

In many cases the simple opening of the abdominal cavity seems to at least temporarily relieve the patient, but the field is so new that we cannot assert positively just what permanent good can be attained by these operations.

Dr. William E. Mosely: Dr. Ashby's case recalls one which I reported fully some time ago. The patient had ascites and I aspirated her twice. Both times the abdomen rapidly refilled with fluid. I then opened her abdomen and removed two papillomatous growths. Three years have now elapsed since the operation; there has been no return of the ascites although the growth has returned.

Dr. B. B. Browne: The question which is brought out most prominently is the propriety and advisability of an exploratory incision in those cases of ascites

in which (heart, liver and kidney diseases having been excluded) no intrapelvic tumor can be felt. Of course where the tumor is large enough to be mapped out the accumulation of ascitic fluid no longer obscures the diagnosis or interferes with any operative procedure which would be called for were no fluid present.

613 Park Ave. WILLIAM S. GARDNER, M. D., Secretary.

PARASITIC ORIGIN OF CANCER.

The last two sittings of the Pathological Society have been occupied with an interesting discussion on a paper by Mr. Jackson Clarke dealing with the parasitic origin of malignant cancer and sarcomatous diseases. In recent years the evidence on this point has been gradually growing stronger and stronger, and the attention of pathologists has been more and more drawn to the consideration of certain forms of organisms that have been described as present in cancer. Scheuerlen first ascribed the symptoms of irritation to the presence of a bacillus —a bacillus which we now know is frequently met with in the skin and probably plays little part as an active etiological factor in the production of cancer; then more recently it has been supposed (1) that budding fungi, (2) that psorosperms, or some similar parasite, might play a part in setting up the necessary process of irritation in cancer. Now, however, we find an observer coming forward to state that in both cancer and sarcoma an enormous number of spore-bearing organisms and free spores may be demonstrated in every specimen in these malignant growths. He maintains that they are not mere dividing protozoa, but that they are more or less closely related to the spore-bearing psorosperms. Such a contention naturally met with very considerable opposition, as its acceptance is almost equal to postulating that a large proportion of such tumors, hitherto recognized as being degenerated cells, giant cells and invading leucocytes, must be looked upon as being parasitic psorosperms in various stages of development. Whatever the immediate outcome of the discussion may be, it can ultimately lead to nothing but good, as it will necessarily draw the attention of a considerable number of histologists to an aspect of the pathology of malignant disease which, though studied by individual observers, has not yet been generally considered.—Editor *Lancet*.

The *Medical News* informs us that the Central Hospital of Philadelphia, just established at the corner of Broad and Race Streets, has instituted an innovation in its administration that is worthy of all praise and imitation. This consists in holding evening clinic-service from 5.30 to 8 o'clock, for poor patients. It is noteworthy that in all the popular zeal for charity and medical help of the poor, it has escaped attention that for a working man or woman to quit work to attend the dispensary in the daytime often really puts him or her to serious inconvenience and to a greater expense in lost time than would result from the call at the physician's private office. A large proportion of dispensary patients have such slight ailments, or they consider them so slight, that rather than lose time from work, they neglect to seek medical advice until the disease has become serious. Taken in their incipiency many affections are aborted. The evening service thus becomes a true charity, and the remarkable success of the Central Hospital clinics, even in these first weeks of the work, is proof that the public perceives the motive of true philanthropy and the skill of the physicians—a most excellently chosen corps—in charge of the clinics.

THE MARYLAND MEDICAL JOURNAL.

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BALTIMORE, APRIL 1, 1893.

Editorial.

THE EVENING DISPENSARY.

With the entrance of women physicians upon practice in Baltimore it was to be expected that one or more dispensaries would be established under their control. The objections brought against the opening of new dispensaries by men could not be urged against those under the care of the other sex; since it is evident that the existing dispensary positions are hardly sufficient for the numbers of young men who desire to profit by the medical experience which the chief of clinic necessarily gains. Dispensaries for physicians of the other sex are just as necessary and their establishment quite as justifiable in this day of "too many dispensaries," as in the case of the first dispensaries for male physicians.

The first annual report of the first dispensary conducted exclusively by women in Baltimore is before us. Its location was evidently well chosen (although South Baltimore practitioners may think it might better have been established elsewhere). And its staff includes a number of the most highly educated women physicians in the city. The work has been wisely planned and is admirably suited to give large clinical experience to those who have charge.

The dispensary is open three evenings and two afternoons in the week.

Voluntary contributions from patients to current expenses are encouraged.

Patients are visited in their homes if necessary, and an outside obstetrical department has been established.

The employment of a trained nurse, in connection with this dispensary, to visit patients and nurse them, or instruct their families in the art of sick nursing, is worthy of note, as marking the introduction of district nursing into our city.

Whatever our readers may think of the wisdom of the patrons who were led to establish the institution by a sense of the need of woman for attention by physicians of her own sex; and whatever they may think of the fitness of women

for the practice of medicine; we are sure that all will agree that, if women are to practise, they ought to have every opportunity for training themselves in the early years of medical life at the dispensary table and at the bedside of the patient.

THE BOARD OF MEDICAL EXAMINERS OF MARYLAND.

The Board of Medical Examiners of the State of Maryland will hold an examination April 20th and 21st at the rooms of the Medical and Chirurgical Faculty, St. Paul and Saratoga Sts.

The examination will begin promptly at 9 A. M., Thursday, April 20th. All persons to whom the medical act applies are required to make written application for license to the President of the Board, Dr. Samuel T. Earle, Baltimore, on or before April 18th.

For this purpose suitable blanks can be obtained by addressing the Secretary, Dr. W. T. Lockwood, 201 W. Madison St., Baltimore, Md.

Copies of the Medical Law may be obtained for ten cents at the office of the Maryland Medical Journal, 209 Park Ave.

NOTE.

We take pleasure in announcing that the papers read before the Philadelphia County Medical Society will be regularly given as original articles in our columns for the coming year, as in the past.

The tone of these papers is very high, and they contain the original observations and mature thought of some of the best teachers and practitioners of America.

Those of our readers who desire to possess them in compact and permanent form may obtain the bound volume of proceedings of the society by communicating with the editor, Dr. Lewis H. Adler, Jr., 1610 Arch Street, Philadelphia, Pa.

Reviews, Books and Pamphlets.

We have received through the courtesy of its president, Dr. W. P. Ewing, of Charleston, the *Biennial Report of the Secretary of the West Virginia State Board of Health*, 1891-92. The volume reflects much credit upon the physicians to whom is entrusted the sanitary oversight of the State. The treatment of the epidemics which have arisen during the last two years shows that the board is awake to the need of advanced sanitary methods. Especially would we concur in its condemnation of the barbarous and disgusting custom of pollution of streams of water by sewage, which still obtains even in our so-called era of civilization.

The laws of West Virginia relating to practitioners of medicine are given in full. Several interesting papers on hygienic themes are included.

We have just received from the publishers, the J. B. Lippincott Company, of Philadelphia, four octavo volumes, which compose the second series, 1892 93, of *International Clinics.*

The work is a quarterly issue of clinical lectures, some illustrated, on medicine, neurology, pædiatrics, surgery, gynæcology, ophthalmology, laryngology, otology and dermatology, contributed by teachers of distinction in the medical colleges of English-speaking countries. Each volume contains perhaps forty lectures.

The work is a very worthy addition to the library of the practitioner. It will not only instruct him in difficult points of special practice, but will afford him profitable entertainment in his leisure hours by the fireside.

The Year-Book of Treatment for 1893; A Critical Review for Practitioners of Medicine and Surgery. A Series of Contributions by Twenty-two Writers. In one 12mo. volume of 500 pages. Cloth, $1.50. Philadelphia: Lea Brothers & Co., 1893.

This volume presents brief selections by a corps of eminent British workers, from the reports of medical advances published in various journals during the past year. Each sub-editor chooses those reports which seem to him to embody the most important work done in the special branch which has been assigned to him. The book is a valuable one to the literary worker, and also, in some degree, to the practitioner.

History of the Life of D. Hayes Agnew, M. D., L. L. D. By J. Howe Adams, M. D. With fourteen full-page portraits and other illustrations. In one large royal octavo volume, 376 pages, extra cloth, beveled edges, $2.50 net; half-morocco, gilt top, $3.50 net. Sold only by subscription. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

This handsome volume appeals to the attention of every practioner, whether surgeon or physician, as the life-record of one of the greatest and most successful workers that the American profession has ever known. In the study of Dr. Agnew's life the reader will discern the natural endowments, and the principles of life, which lie at the foundation of true greatness in every calling. A born doctor, Dr. Agnew devoted himself with intense earnestness at the beginning of his medical career to that study of anatomy on which operative surgery must be based. By unflagging industry he won a reputation for surgical skill so great that he was chosen as chief consultant for the wounded President of our nation. His teaching powers gave him the commanding position of Professor of Surgery in the University of Pennsylvania. His literary works are known to all. His varied accomplishments were crowned by a simple religious faith and walk as a christian. The work of his biographer gives evidence of laborious research, as well as of loving appreciation of his theme.

The library of the physician is incomplete without the addition of at least one such biography, wherein he may, in leisure hours, find food for meditation and impetus to a nobler life.

Among the books and pamphlets received during the past week was the beautiful little souvenier hand-book of the New York Pharmaceutical Co. This little publication is gotten up in a most artistic and handsome manner, being beautifully illustrated throughout, and presenting to the profession points of interest regarding the uses and benefits of Virbunum Compound and Uric Solvent. A copy will be sent free to any physician who will address the New York Pharmaceutical Co., Bedford Springs, Mass.

Pan-American Congress.

SECTION OF THERAPEUTICS.

Dr. H. A. Hare, President of the Section on Therapeutics of the Pan-American Medical Congress, requests us to state that it is the earnest desire of the officers of the section on therapeutics of the Pan-American Medical Congress that both specialists and general practitioners should contribute articles to its proceedings.

Gentlemen who desire to read papers at this meeting should notify the undersigned at once of their intention, and should send him by July 10th at the latest an abstract of their paper in order that it may be translated into the three official languages of the Congress and published in the program. The importance of this section and the interesting papers which have already been promised give assurance of a very successful meeting.

SECTION OF GENERAL MEDICINE.

This section, which is one of the most important that has been created, bids fair to be one of the most successful in the entire Congress; and already many valuable contributions are in process of preparation, and will be read at the meeting in September. It is hoped, with the hearty co-operation of all physicians living not only in the North but also in South and Central America, that the work in this section will be memorable; and each physician living ont his continent is requested to join this most important section, and to prepare a contribution to be read before that body. It is especially requested that those intending to join this section or to read papers shall at once send their names, with titles of papers, to the secretary, Dr. Judson Daland, No. 319 South Eighteenth Street, Philadelphia, Pa., so that they may be noted on the calendar and given their appropriate place.

SECTION ON DERMATOLOGY AND SYPHILOGRAPHY.

This section has been organized as follows: Honorary Presidents: Dr. Silva Aranjo, Rio de Janeiro, U. S. of Brazil; Dr. L. Duncan Bulkley, New York; Dr. Juan C. Castillo, Lima, Peru; Dr. Louis A. Duhring, Philadelphia; Dr. Le Grand N. Denslow, St. Paul; Dr. Maximiliano Golan, City of Mexico, Mexico; Dr. James Nevins Hyde, Chicago; Dr. Prince A. Morrow, New York; Dr. R. B. Morison, Baltimore; Dr. D. W. Montgomery, San Francisco; Dr. A. Ravogli, Cincinnati; Dr. A. R. Robinson, New York; Dr. Antonio Rubio, Pinar del Rio, Cuba; Dr. M. Lucas Sierra, Santiago, Chile; Dr. R. W. Taylor, New York; Dr. A. Van Harlinger, Philadelphia; Dr. J. C. White, Boston, Mass.; Dr. Edward Wigglesworth, Boston, Mass.

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Communications, notices of papers, etc., should be sent to the Secretary, Dr. W. S. Gottheil, 25 W. 53rd Street, New York City.

Medical Progress.

TREATMENT OF ULCERS BY STRAPPING.

Dr. C. E. Quimby advocates this method of treatment, which is carried out as follows:

1. Adhesive straps should not be over one inch in width, and usually a narrower strap is to be preferred.

2. Straps should be as short as is consistent with a firm hold on healthy skin, and should never fully encircle the limb.

3. All straps should be applied at *right angles* to the long axis of the ulcer, subject to slight modification by the direction of greatest cutaneous elasticity, and are to be adjusted in two sets.

First set:

4. These straps are applied in the usual manner by fixing one end on healthy skin and approximating the edges of the ulcer as the other end is applied and fixed.

5. The first *strap* of this set should *bisect the ulcerated surface.*

6. Each succeeding strap of this set should bisect uncovered ulcerated surfaces.

7. As any strap becomes loosened, one end should be freed and reapplied under appropriate tension.—*Kansas City Medical Record.*

CYSTITIS IN WOMEN.

In a discussion of a paper by Dr. Amelia J. Prior on this subject in the Cincinnati Medical Society, Dr. Stanton said(*Lancet-Clinic,* March 25): I think we all agree that local treatment is the most important in these cases. I do not altogether agree with the essayist in reference to constitutional treatment. It seems to me that palliation can often be secured by constitutional treatment. For instance, an irritation in the bladder, produced by the salts of the urine, will be relieved by remedies which increase the flow of the water, thus diluting the urine. Thus belladonna with diuretics will frequently give relief. Couchgrass is frequently prescribed with great benefit in these cases. I believe the greatest benefit is secured by the increased flow of water, causing a diminution of the irritation produced by the salts of the urine or whatever irritating substance may be present. The principal good is obtained from the administration of

soothing remedies, which relieve the irritation of the bladder, especially by causing dilution of the salts of the urine. I think the local treatment, while it is of the most importance, certainly is not the only treatment, but is an excellent palliative measure. With regard to the use of local remedies in this disease, I have not had much experience with boracic acid, but where I have used it I have found it beneficial. I certainly would give preference to it in a recent case in which other remedies had not been tried, but otherwise I would resort to the use of nitrate of silver in a weak solution, gr. ½ to the ounce, injecting the fluid into the bladder and withdrawing it by means of a syringe soon after the injection. Years ago Dr. Shaw read a paper in which he mentioned having used a solution of grs. xl to the ounce. He certainly had a very happy result, but I should hesitate to use an injection of that strength. Dilatation of the urethra and frequent evacuation of the bladder will give a great deal of relief and assist in the cure of these cases. Distention of the bladder aggravates the disease, and relief should be given to the organ, and it should not be permitted to be distended. Cases of pericystitis are sometimes quite annoying where there is retention of urine after delivery, and the catheter has to be used. Dilatation sometimes would be likely to give relief, and I think it is an operation which is not resorted to as often as it ought to be in a disease attended with as much distress as this. There are new methods of treatment recommended for cystitis. One is curetting the bladder, and another is dilating and swabbing out the bladder. These I have never tried, and it seems to me both are methods more likely to be productive of evil results than good, unless performed by an experienced operator.

TREATMENT OF GONORRHŒAL RHEUMATISM.

To be rational it must be administered according to the stage of the disease and the condition of the patient.

When the attack begins within a short time after the gonorrhœa is contracted I would advise the following: If pain is severe, give hypodermic of morphine, wrap the affected part in flannel wrung out of water as hot as can be borne, or poultice, place the part on a splint, or in any way to limit motion. Give a cathartic to gently open the bowels, and administer ten grains of salol every three hours, unless it affects the urine too much, which can easily be told by its becoming dark. Liberal, nourishing diet and rest in bed. If injections are being used stop them, or use very mild cleansing washes.

Salol does good, I am sure of it; it lessens the general pains, combats the pyæmic condition present, and its elimination almost wholly by the kidneys, in the form of salicylic and carbolic acids, exerts a favorable influence upon the gonorrhœal discharge. Much the same may be said of salicylate of soda.

The test for both salicylic and carbolic acid is the same, and can be readily made, as Bartholow points out, by adding to the urine suspected to contain them, drop by drop, chloride of iron, which, if either acid be present, soon strikes a fine violet color.

If the so-called rheumatism comes on when the discharge is old, it will be necessary to treat the old pus-secreting surfaces in the posterior urethra.

If suppuration takes place in joints, open freely and keep clean by antiseptic washes, such as bichloride, iodide water and peroxide of hydrogen. Massage and motion in latter stages.

After all this many cases will improve slowly, but in the majority of cases satisfactory results will be obtained.—Dr. Little, *Northwestern Lancet*, March 15.

GONORRHŒAL INFECTION OF THE MUCOUS MEMBRANE OF THE MOUTH IN NEW-BORN INFANTS.

From the study of five cases of gonorrhœal infection of the mouth in the Königsberg Obstetrical Clinic, Dr. Rosinsky has drawn the following picture of the disease: Without preceding inflammatory redness, a white discoloration appears upon the anterior two-thirds of the tongue, the plaques of Bednar, the hamulus pterygoideus, and along the ligamentum pterygomandibularum in the lower jaw, finally upon the front parts of the gums. After twenty-four to thirty six hours the color becomes yellow. The patches elevate themselves plateau-like over the surrounding tissues, and their surfaces are raw. The superficial epithelium forms with extravasated pus-cells, a thick layer, resembling the scrapings from the cut surface of a septic spleen. On the third day the regeneration of the epithelium begins; this is marked by an inflammatory redness around the edge of the patch. Healing follows without treatment, in an ideal manner, no trace of scar or discoloration remaining. From the microscopical examination of some excised tissue, Rosinsky has gleaned the following: The gonococci were never found, in stained sections, intra-cellular. They were seldom found intra-cellular in the superficial flakes. Gonococci cannot penetrate into the body of healthy, living cells; they accomplish this only when the single cells are cut off from the conditions of life. In the connective tissue gonococci invasion was found. Rosinsky believes this to be typical pure gonorrhœal inflammation of the mucous membrane. The relatively infrequent gonorrhœal inflammation of the mucous membrane of the mouth in adults, in contradistinction to infants, he believes to be due to the tenderness of the epithelium of the mouth in the new-born.—*Annals of Gynæcology.*

A NEW USE FOR THE SPLEEN.

Drs. Pizzoni and Pattani have, through experimentation upon animals, discovered that the spleen is a necessary factor in the production of immunity from infectious diseases. Guinea-pigs, from which the spleens were removed, were found to become permanently incapable of being rendered immune to the virus of tetanus. This discovery may have a marked influence in clearing up some of the mooted questions relating to immunity. It may be possible that this organ becomes the store-house of the various anti-toxines produced during the course of the infectious diseases. The fact that this organ enlarges during the course of this class of diseases might serve as a clew from which valuable facts can be obtained. Our ignorance concerning the functions of this ductless gland makes the organ a promising field for study.

WHAT IS A "FELON?"

Burrell (*Boston Medical and Surgical Journal*, February 4, 1892) is convinced that the term "felon" is very loosely applied to a variety of inflammatory diseases of the finger, and suggests that this term should be abolished and an anatomical classification of the inflammatory affections of the finger be adopted. The classification he proposes is: (1) Dermatitis; (2) paronchia; (3) cellulitis of the finger; (4) suppurative thecitis; (5) periostitis or ostitis of the phalanges. While he feels sure that most practitioners distinguish these various affections, he maintains that the distinction is frequently not made in name, and that the common text-books on surgery neglect to clinically distinguish them. The treatment of these various conditions differs. Dermatitis requires local applications; paronchia, an incision through the nail or its removal, with a proper dressing afterward; cellulitis, a limited incision into the pulp of the finger with evacuation of the pus; suppurative thecitis, an incision through

the sheath of the tendon, evacuation of the pus, antisepsis and immobilization of the fingers, hand and arm; periostitis or ostitis, an incision down through the periosteum at the earliest moment. These affections run into one another, and it is at times impossible to make a clear distinction between them; but the distinction is needed; for an incision down to the periosteum is worse than useless in dermatitis, and not necessary in any except in periostitis or ostitis, where such an incision is imperatively demanded.—*Ex.*

Recommendations of Therapeutic Agents.

Physicians are always interested in new and reliable pharmaceuticals that are placed on the market. Among the latest novelties in elegantly manufactured preparations, we call your attention to the Perloids, or improved pearl-shaped capsules, just placed on the market by the progressive capsules house, H. Planten & Son, New York, and of which we have been favored with samples.

The manufactures inform us that "perloids" are prepared from the finest materials by improved processes and special machinery and filled with such valuable medicinals as apiol, copaiba, creosote, cubeb oil, damiana, morrhual, pure and with creosote, sandal oil, terebene, turpentine, etc. They are readily swallowed, perfectly soluble, symmetrical of shape and elegant of finish, making the desideratum for prescribing.

We suggest that you send for samples of perloids as well as of the hard and soft capsules made by H. Planten & Son, 224 William St., New York, and acquaint yourself with the very superior goods manufactured by this firm.

Medical Items.

We are pleased to report that Dr. Geo. W. Massamore, who has for some time been on the list of inaugural victims, is recovering from the effects of a severe cold, contracted in washington on inauguration day.

Mayor Latrobe has directed Dr. Heiskell to issue the necessary orders to carry into effect the maritime regulations against foreign vessels on and after April 1st, and those against coastwise vessels on and after May 1st.

Dr. Mary Putnam Jacobi was elected as president of the Neurological Section of the New York Academy of Medicine, at its last meeting, to succeed Dr. Graeme M. Hammond.—*Omaha Clinic.*

Goodell says: "A nervous bladder is one of the earliest symptoms of a nervous brain; for nervousness means a deficient control of the higher nerve centers over the lower ones; the vesical irritability indicates a lack of brain control."—*Omaha Clinic.*

The Minnesota Medical Society is attempting now the passage of an act to regulate medical experts. Its purport is that the judge shall have the power to select the expert in all medical, mechanical and scientific questions, and that these experts shall be paid as witnesses for the State.

The oldest newspaper in the world is the "*Pekin Gazette*" which has been regularly published since A. D. 911. It has now three issues daily (not merely edi-

tions) with a circulation of ten thousand. The oldest European newspaper still published is the "*Post Zeitung*" of Frankfort, which dates from 1616.—*Ex.*

A snake laboratory for the study, under strictly scientific conditions, as snake poisons and cures for snake bites is to be established in Calcutta. It is to be founded by a native of the province and will be the only institution of the kind in the world. It will be thoroughly equipped and perfect in every respect.—*Ex.*

The most curious of all journals is probably the "*Beggars' Journal*" of Paris, which is published daily, and gives its subcsribers a complete list of baptisms, weddings, and funerals to take place the same day, which may be assumed to afford a good "pitch." Begging letter-writers are provided for by a special section, which gives the arrivals and departures of persons of known charitable tendencies.—*Weekly Review.*

Mrs. Frances S. Wilton, superintendent of nurses and matron at the University of Maryland Hospital, will resign April 1. Mrs. Wilton has had charge of hospitals in several cities. She was formerly at the Home for Incurables in Baltimore. She has been at the University of Maryland two years. In addition to her duties as matron and superintendent of nurses she instructed the nurses in their second-year course. Miss Hale, who was assistant superintendent, will become superintendent and instructor of nurses. Dr. Clarence Spruill, who has been resident physician, will become medical superintendent of the hospital.—*Sun.*

At this time of the year physicians should look over the list of babies at whose birth they have presided during the past twelve months, and should see to it that they are all vaccinated before the end of the month, for with warm weather and the renewal of travel and immigration will come the greatest danger of the appearance of small-pox, while on the other hand the summer is the poorest time of the year in which to vaccinate, since it is difficult to preserve the virus for any length of time, and the proportion of failures after inoculation is consequently larger than during cold weather. It is clearly the duty of the family physician to see to it that the little ones under his charge are properly protected by vaccination, but this is a duty which the medical man is wont to neglect, sometimes to his sorrow.—*Northwestern Lancet.*

In many nurseries in England there is to be found upon the wall a large card, perhaps 2x3 feet. At the top of the card is written the name and address of the nearest doctor, or the one to be called in case of accident. Beneath are the words, "What to do and how to do it." There is a list of the accidents most liable to happen to children and the remedy for each. Bites and swallowed buttons, bleeding nose, burns, convulsions, stings, bruises and sprains and poisons are all provided for, and in a box beneath the card are kept absorbent cotton, court-plaster, lint, arnica and various necessaries that are only to be used in cases of accident. When general chaos reigns, and even the intelligent have lost their wits, this card is invaluable. To be able to read and understand it might be one of the tests used in engaging a nursemaid. Printed cards could probably be read more readily than those written.—*Ex.*

The graduating class of the Woman's Medical College, on Hoffman Street and Druid Hill Avenue, retired in a body from the presence of one of the lecturers a few days ago. In a series of resolutions handed to the dean of the college, they peremptorily refused to attend the lecturer's instruction for the

remainder of the season, alleging as the cause ungentlemanly deportment and the unsatisfactory handling of the subject. The lecturer in question is not a professor of the faculty. It is said that the "ungentlemanly deportment" consisted of what the students considered unnecessarily harsh reproof of what the lecturer deemed was inattention on part of the class, and that the pupils, being grown women, object to being reproved as if they were children. Hence the strike. As to the "unsatisfactory handling of the subject," it is said that the class does not consider the lecturer in question enough of an authority on the special subject to give instruction to the candidates for graduation. The dean declined to say anything about it and the matter has not yet been settled.—*Sun.*

The "National Bureau of Medical Bibliography and Departmental Information," 102 Ninth St., S. E., Washington, D. C. calls our attention to the announcement that, at the urgent solicitation of many medical men and others interested in literary research and bibliography, it has established at the National Capital a Bureau of Medical Bibliography and Departmental Information for the convenience and accommodation of authors, lecturers, practitioners and others residing at a distance, who are desirous of availing themselves of the vast collections of such works as are contained in the Medical, Scientific and Congressional Libraries at Washington.

The Library of the Surgeon General's Office, U. S. A., is the largest medical library in the world, and contains more than three-fourths of all the medical literature ever published. Here, also, are to be found complete files of all the medical journals, transactions of medical societies, boards of health, hygiene, &c., and the vital statistics of all countries.

The Bureau announces that it is prepared to furnish complete bibliographies of any given subject in medicine, surgery, &c., or abstracts and translations from original papers in all languages, as well as copies in the original at small cost. Information relating to matters connected with any of the Government Departments will also be furnished when requested. Address as above with stamp, stating clearly what is desired.

We regret to learn, through the Baltimore *Sun*, of the death, in his eightieth year, of one of Boston's most accomplished and most public-spirited physicians, Dr. Geo. C. Shattuck. The *Sun* gives the following brief account of his career: He studied medicine in Boston and in Paris, and long occupied a very high position in his profession. He was a fellow of the American Academy of Arts and Sciences, for thirty-six years was visiting physician to the Massachusetts General Hospital and for twenty years professor in the Medical College of Howard University. For many years also he delivered lectures annually to the students of St. James College, Maryland, and of Trinity College, Hartford, on physiology and hygiene. Inheriting an ample fortune, he devoted himself to his profession, not for the emoluments to be derived from it, but to advance the science of medicine and to do good to others. His charities and benefactions were many in number, and his sterling character and professional qualities won for him hosts of friends. He was strongly attached to the Protestant Episcopal Church, to the general conventions of which he was constantly sent as a delegate. In 1855 he founded the famous St. Paul's School, in Concord, N. H. (whose rector, Dr. Colt, is beloved by two generations of scholars), giving to the new foundation the house and lands which had been his country home, and from time to time making to it additional gifts, the sum of them being estimated, in

a recently published history of the school, at $100,000. Many Baltimoreans, probably nearly a hundred in all, have been educated at this school.

When Bishop Brooks, of Massachusetts, was welcomed after his election at a dinner by the Episcopal Club of Boston in October, 1891, one of the speakers (to quote from the account in the *Boston Herald*) "made a touching reference to his old friend, Dr. Shattuck, and as he mentioned his name every man in the room rose to his feet and remained standing while he was speaking." Dr. Shattuck was well known in Baltimore, where he often visited, and among his friends here were the leading physicians of an earlier day, the Mackenzies, Bucklers, Dr. Smith, Dr. Johnston, Dr. Donaldson and others. During recent years his face became somewhat familiar to a good many of our lawyers, owing to the fact that often, when the late Judge Brown was sitting in court, Dr. Shattuck would occupy a seat next him on the bench, listening to the proceedings. His wife, who survives him, was the daughter of the late Frederick W. Brune, Sr., of this city, who was the founder of the firm of F. W. Brune & Sons.

The commencement exercises of the dental department of the University of Maryland were held March 16, in the Concert Hall of Harris's Academy of Music. They were opened with prayer by Rev. E. L. Watson. Dr. Ferdinand J. S. Gorgas, dean of the faculty, read the mandamus, and Dr. I. E. Atkinson conferred the degrees. The graduates were F. Loveland Arnold and Thomas W. Rowe, of Rhode Island; S. DeLeon Avery and J. Edwin Boozer, of South Carolina; William H. Barr, Roland E. Loucks and C. Howard Nicholson, of Canada; Samuel E. Boyd, William Lee Davis and John S. Rees, of California; Henry Winter Davis and William W. Farmer, of Virginia; Samuel M. Byers, of Pennsylvania; Norwood G. Carroll, of North Carolina; Willie E. Minghini, of West Virginia and D. Fleming Sallis, of Mississippi. The address to the graduates was made by Rev. E. Watson. C. Howard Nicholson, of Canada, was class orator. The exercises were interesting and the large audience testified their appreciation with hearty applause. Prizes were awarded by Dr. I. E. Atkinson as follows: University prize, gold medal, for highest grade on final examination, Roland E. Loucks, of Canada; honorable mention, C. H. Nicholson, Canada. S. S. White, prize, a dental engine, H. W. Davis, Virginia; honorable mention, John S. Reese, California. Snowden and Cowman prize, a set of forceps, Henry Winter Davis; honorable mention, John S. Reese. The Arnold prize, set of forceps, John S. Reese; honorable mention, C. H. Nicholson. James Hart prize, gold medal, John S. Reese; honorable mention, Roland E. Loucks. S. S. White prize, set of Vainey's instruments, W. Lee Davis, of California; honorable mention, Samuel M. Byers, of Pennsylvania. Professor James H. Harris prize, gold medal, W. W. Farmer, of Virginia; honorable mention, C. H. Nicholson. Professor F. J. S. Gorgas prize, gold medal, N. G. Carroll, of North Carolina; honorable mention, D. F. Sallis, of Mississippi. Dr. Frank L. Woods prize, gold medal, N. G. Carroll, of North Carolina; first honorable mention, R. E. Loucks; second honorable mention, S. M. Byers. Dr. John C. Uhler prize, gold medal, Samuel M. Byers; honorable mention, John S. Reese. Dr. Isaac H. Davis prize, gold medal, William H. Barr, of Canada; honorable mention, C. H. Nicholson. Dental department prize, gold medal, W. Lee Davis; honorable mention, R. E. Loucks. Dr. H. E. Neiman prize, a vulcanizer, W. Lee Davis; honorable mention, Samuel M. Byers. The prizes were awarded according to the judgment of twenty-five dentists, who were invited to act as judges by the dean of the school, Dr. F. J. S. Gorgas. The faculty stated that the class was necessarily small this year on account of the new rule having been enforced requiring three instead of two sessions before graduation.—*Sun.*

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Original Articles.

A PRELIMINARY COMMUNICATION ON SOME OF THE TROPHO-NEUROSES ASSOCIATED WITH ABNORMALITY OF THE THYROID GLAND.*

BY SOLOMON SOLIS-COHEN, M. D.,

Professor of Clinical Medicine and Applied Therapeutics in the Philadelphia Polyclinic, Etc.

Dr. Solomon Solis-Cohen reported and exhibited photographs of two cases of akromegalia, in both of which there was apparent absence of the thyroid gland, and marked skeletal changes in addition to those in the face, hands, and spine. The patients were males, one twenty-five years of age, the other fifty-one years old. In neither case was there any eye-lesion. The case of the younger man had been previously reported to the College of Physicians. In the elder man headache, drowsiness, forgetfulness, thickness and scanning of speech, and excessive polyuria was present. The symptoms had been partially relieved by picrotoxin, the headache especially. This drug was a vasomotor regulator and useful in many of the conditions to be discussed. It was necessary to say "apparent absence" of the thyroid gland, because only *post-mortem* could absence or atrophy be unqualifiedly affirmed. Embryologically the pituitary body and thyroid gland were intimately related, and it appeared not improbable that the enlargement of the

*Abstract of a paper read February 8th, before the Philadelphia County Medical Society.

former and the consequent hemiopia and other cerebral symptoms noted in some cases of akromegalia might be due to an attempt by nature to supply the absence of an important structure by compensatory hypertrophy of an allied structure.

A number of cases in which the thyroid gland could not be demonstrated and which presented some, but not all, of the changes found in typical cases of akromegalia, were likewise related. In one such case the hands and ears presented marked local asphyxia (Raynaud's disease), while the pain and the transient redness developed in the feet upon exertion were suggestive of the condition described by Weir Mitchell under the name of erythomelalgia. In another case, in an aged man, there were cardiac lesions and muscular tremors, with wasting, as in progressive muscular atrophy.

Other cases observed by the speaker in which thyroid atrophy apparently existed were: one case of hypertrophic osteo-arthropathy with emphysema and fibroid phthisis, in a man fifty years of age; one case of scleroderma with cardiac lesions, muscular tremors and mental changes in a woman apparently quite aged, who insisted, however, that she was less than forty years old; and one case of unilateral spontaneous gangrene and ulceration of the toes and leg (Raynaud's disease), with bilateral spasmodic vascular phenomena in a woman over sixty years of age. In the latter case certain changes in the fingers and nails existed, which in one finger resembled those of akromegalia, in another finger those of rheumatoid arthritis, in another finger those of sclerodactyle, the nails of all the fingers being curved like those of the Hippocratic finger, as in pulmonary hypertrophic osteo-arthopathy. That this latter condition of the nails and finger tips could be ascribed to interference with nutrition through the circulation was held to be shown by the occurrence in cases of cardiac disease without pulmonary or obvious nervous lesion of fingers indistinguishable, and of which pictures and tracings were exhibited.

Taking up conditions of trophic and vascular disturbance associated with enlargement of the thyroid gland, Dr. Cohen briefly alluded to exophthalmic goitre, myxœdema and cretinism, laying stress upon the fact that as, on the one hand, in akromegalia there might be enlargement instead of apparent absence or atrophy of the thyroid gland, so, on the other hand, in myxœdema and cretinism, the goitre might be lacking, while experimental thyroidectomy, as well as the *cachexia strumipriva* that followed surgical extirpation of the gland, proved that the symptoms were due to a functional atrophy of the gland, whether or not there was hyperplasia of the non-essential anatomical elements. Stress was laid upon the varied vasomotor disturbances in all these marked conditions.

In one case of Raynaud's disease, an affection which, so far as the vasomotor phenomena are concerned, is almost an antithesis of Graves's disease, Dr. Cohen had observed in an anæmic girl, with occasional tachycardia, an intermittent enlargement of the thyroid, just as is observed in certain cases of exophthalmic goitre, and in certain ill-defined cases for which he had proposed the name of *vasomotor ataxia*, which latter could not be called exophthalmic goitre, but in some instances might readily develop into that condition. These latter cases,

observed both in males and females, but principally in the latter, and in hysterical subjects more often than in others, showed as an almost constant feature the intermittent presence of hæmocytes in the urine; sometimes, but rarely, transient or intermittent albuminuria as well. In some cases lithuria and oxaluria had been noted, especially in those of rheumatic, gouty, or diabetic families; still more rarely casts or cylindroids had been found. These observations were related with the occurrence of hæmoglobinuria in Raynaud's disease, and of hæmaturia and other hæmorrhages, such as purpura, hæmoptysis and hæmatemesis, all of which the speaker had personally witnessed, in Graves's disease; as well as with the occasional albuminuria of the latter, and the polyuria, albuminuria and glycosuria of myxœdema and of akromegalia, and the morbid perspiration and localized œdemas and flushes of all these conditions, and of angio-neurotic œdema—in which latter condition he had also found hæmocytes in the urine during and after paroxysms affecting the throat in one woman and the arms of another. In some of his cases of vasomotor ataxia, a condition which varied much in its severity, from but slight abnormality to such marked affections as those associated with the names of Graves and Raynaud, the author had observed hæmatemesis, with symptoms suggestive of gastric ulcer, anæmia, menstrual irregularities, migraine, trasient localized œdema, transient local blushing, permanent dilatation of isolated groups of capillaries and venules, stigmata, local syncope, erythema nodosum, and urticaria; in one case there had been transient blindness. In two other cases, in which, however, no thyroid abnormality had been detected, there had been membranous enteritis. Subjective and objective coldness of the knees was marked in one case in which the thyroid was enlarged. In another case, the first observed by Dr. Cohen in a male, there had been great rapidity of the heart's action and intermittent goitre as well, so that the case might well have been called Graves's disease, and doubtless belonged positively in that category. Strictly circumscribed erythema and factitious urticaria could be readily produced in all these cases by writing upon the skin with a probe, or in some instances applying cold to the part. In a colored woman with exophthalmic goitre the effect was almost startling.

The connection of rheumatism with Graves's disease, and the heredity of both, was too frequent to be a mere coincidence. In certain cases of rheumatoid arthritis the thyroid gland was found to be enlarged, and tracings were shown of the fingers of an old man with rheumatoid arthritis and arthritic muscular atrophy, in which the parrot-beak pad and nail were shown in the terminal phalanx of the thumb, which was hyper-extended, while the sharpened and atrophied terminal phalanges of other fingers resembled sclerodactyle, and were almost identical with the tracings from the case of Raynaud's disease. Allusion was made to the tetany of thyroidectomy and the tremors of exophthalmic goitre, some cases of myxœdema, the speaker's cases of scleroderma and of Raynaud's disease, and some of his cases of vasomotor ataxia; as also to the occurrence of phenomena like Raynaud's disease in certain cases of scleroderma, the anæmia and the ex-

treme susceptibility to cold, which was a feature of all the conditions described. To complete the list of associations observed, and admitting that they might be coincidental, there were many reported in connection with the occasional occurrence of epilepsy in Graves's disease, two cases of the speaker's, in one of which *petit mal* had developed in an anæmic girl with enlarged thyroid and occasional tachycardia, and in the other, a male, with enlarged thyroid, tachycardia and flushed face accompanied the epileptic paroxysm. The not infrequent termination in phthisis of many of the conditions alluded to might have no other significance than impaired nutrition, but the recent observation of hæmoptyses occurring only during paroxysm in one case of epilepsy without appreciable pulmonary lesion, and in one case of local asphyxia with but trifling signs on the chest and a few tubercle bacilli in the sputum, had suggested the thought that vascular disturbances in the lung might be the determining factor. Finally, attention was called to the success of various observers in treating myxœdema by implantation of a thyroid gland, by injections of thyroid extract, and by feeding with fresh thyroids. It was suggested that the same treatment might be of benefit in many of these varied conditions narrated.

The speaker desired to avoid premature assertion of causal relationship, and had therefore made use of the words "associated with," rather than "dependent upon" abnormality of the thyroid gland, in describing the trophic, neurotic, and neuro-vascular phenomena discussed; some of the complicated associations he had been unfortunate enough to meet with were doubtless purely fortuitous. The tendency of diagnosticians was naturally to discriminate among groups of phenomena presenting similarities, and thus to divide rather than unite. Nevertheless, the student of pathology in its broad sense, must be on the alert for commonalty of phenomena, and certainly the very variety of the nutritional disturbances associated with abnormalities of the thyroid gland indicated a profound relationship among them, dependent upon the important metabolic functions of the gland.

The researches of many observers, in particular Horsley, had demonstrated this metabolic importance, and that the secretions of the gland acted in the organism in some way. Dr. Cohen believed that they were in truth chemio-tactic or regulatory, and that individual constitution, heredity, environment, habits, and the like, determined the particular direction in which failure of their function would be manifested. Most certainly an intimate relation existed between the thyroid gland and the visceral nervous system, more especially the vasomotor mechanism. Of course, under the conditions, it was difficult to separate primary from secondary phenomena—the mediate results of the train of action of a mechanism from the immediate results of the influences that had set the mechanism in action. The main purpose of the paper was to suggest more common observation clinically and at autopsies of the thyroid gland, so that sufficient data might be collected by a number of observers in order to determine what is accidental and what is essential.

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BALTIMORE, APRIL 8, 1893.

Editorial.

OUR STATE MEDICAL SOCIETY.

The annual meeting of the Medical and Chirurgical Faculty will be held in less than three weeks from this date (4th Tuesday in April).

The thought of its near approach should stimulate every member to consider how he may add to its interest and instructivenesss.

The aims of the meeting would be greatly advanced if more of our county members would make arrangements for a short trip to Baltimore during its sessions.

In consideration of the efforts put forth in the past by the Faculty toward arousing a spirit of medical fellowship in the towns and counties of the State, it would be well for county societies, of which there are now several in Maryland, to send large delegations to the annual Faculty meeting. And the Faculty should devise some means of specially recognizing such delegations at its sessions and in its social gatherings.

These social assemblies will doubtless be so arranged as to suit the convenience of visiting members better than in past years.

In other associations special arrangements are made and announced beforehand by the authorities, for the entertainment of visiting members in the homes of city members. This might be done here, and it would doubtless greatly promote friendship in the profession throughout the State.

Would it be too much to suggest that some tasteful decoration of the Faculty hall would make its sessions more attractive? It is done in other great assemblies.

The need of a medical stenographer to report the proceedings, papers and discussions of the Faculty is a very pressing one. Members are much more apt to prepare for discussions if these are to be published in full in the journals from shorthand notes. Valuable addresses have been lost to the reading public for

want of a stenographer. The President's address of last year is still unpublished because he has not yet had time to write it out, and the oration of the preceding year was lost for the same reason. Since the medical stenographer who reports for three of the city societies is available to do the work, the Faculty should certainly secure his services.

It is well that preparation of papers designed for the Faculty sessions should be commenced as soon as possible. Partially written out or ill-digested papers, or addresses given wholly from memory for want of time to write them, are objectionable, as tending, in most cases, to waste the time of the members or to lower the average of literary work presented to the society.

Reviews, Books and Pamphlets.

A Treatise on (or Text-book of) the Theory and Practice of Medicine; by American Teachers; edited by WILLIAM PEPPER, M. D., LL. D. In two handsome royal octavo volumes, of about 1000 pages each, with illustrations when necessary. For sale by subscription only. Price per volume, cloth, $5; sheep, $6; half Russia, $7. W. B. Saunders, Publisher, 913 Walnut St., Philadelphia, Pa.

Volume I, now before us, contains articles upon the following subjects:

Hygiene, J. S. Billings, M. D., Professor of Hygiene, University of Pennsylvania.

Fevers (ephemeral, simple continued, typhus, typhoid, epidemic cerebro-spinal, meningitis, and relapsing).—William Pepper, M. D., Provost and Professor of the Theory and Practice of Medicine and of Clinical Medicine, University of Pennsylvania.

Scarlatina, measles, rotheln, variola, varioloid, vaccinia, varicella, mumps, whooping-cough, anthrax, hydrophobia, trichinosis, actinomycosis, glanders, and tetanus.—James T. Whittaker, M. D., Professor of the Theory and Practice of Medicine and Clinical Medicine, Medical College of Cincinnati, Ohio.

Tuberculosis, scrofula, syphilis, diphtheria, erysipelas, malaria, cholera, and yellow fever.—W. Gilman Thompson, M. D., Professor of Physiology, New York University Medical College.

Nervous, muscular and mental disease (including opium habit, etc.).—Horatio C. Wood, M. D., Professor of Materia Medica, Pharmacy, General Therapeutics, and Clinical Professor of Nervous Diseases, University of Pennsylvania; and William Osler, M. D., Professor of Practice of Medicine, Johns Hopkins University, Baltimore, Md.

Volume II (soon to be issued) will contain articles upon the following subjects:

Urine (chemistry and microscopy of).—James W. Holland, M. D., Professor of Medical Chemistry and Toxicology, Jefferson Medical College, Philadelphia.

Kidneys and Lungs.—Francis Delafield, M. D., Professor of Pathology and Practice of Medicine, College of Physicians and Surgeons, New York City.

Air-passages (larynx and bronchi) and pleura.—James C. Wilson, M. D., Professor of Practice of Medicine and Clinical Medicine, Jefferson Medical College, Philadelphia.

Pharynx, œsophagus, stomach and intestines (including intestinal parasites).—Wm. Pepper, M. D., Provost and Professor of Practice of Medicine, University of Pennsylvania.

Peritoneum, liver and pancreas.—R. N. Fitz, M. D., Shattuck Professor of Pathological Anatomy, Harvard Medical School.

Diathetic diseases (rheumatism, rheumatoid arthritis, gout, lithaemia and diabetes).—Henry W. Lyman, M. D., Professor of Principles and Practice of Medicine, Rush Medical College, Chicago.

Heart, aorta, arteries and veins.—E. G. Janeway, M. D., Professor of Principles and Practice of Medicine, Bellevue Hospital Medical College, New York City.

Blood and spleen.—William Osler, M. D , Professor of Practice of Medicine, Johns Hopkins University, Baltimore, Md.

Inflammation, embolism, thrombosis, fever and bacteriology.—W. H. Welch, M. D., Professor of Pathology, Johns Hopkins University, Baltimore, Md.

We need hardly take space for criticism of the contents of the very handsome volume, which, with its neat clear type, lies open before us. It suffices to state it contains the best and latest information possessed by the eminent teachers and authors above-named; who certainly represent, although they do not of course exhaust, the highest medical culture of America. The publisher is to be congratulated on his steady advance to the very highest class of medical publication work.

First Annual Report of the Free Sunday Breakfast and Rescue Association of Baltimore. Its objects and methods, with a sketch of its proposed forward movement. Baltimore: Press of Guggenheimer, Weil and Co., 1893.

This is a movement for the aid of those who suffer from chronic indisposition to work, or from inability or disinclination to keep a place when they get it. They form a very dangerous element in the community.

The best authorities hold that such rescue effort ought to stand firmly by the principle, that if a man will not work for food and lodging he shall not get it.

The best organization for such rescue known in English-speaking countries is the Salvation Army. In England General Booth reports that fifteen per cent. of the chronic unemployed can be taught habits of steady work. For the treatment of the remaining eighty-five per cent., work-houses managed by a purified city government are necessary.

Books and Pamphlets Received.

Irrigation of the Urethra and Bladder by Posture and Continuous Current; B. H. Daggett, M. D., Buffalo, N. Y. Reprint from *Buffalo Medical and Surgical Journal,* March, 1893.

Modern Homœopathy, its Absurdities and Inconsistencies; a Prize Essay; by W. W. Browning, M. D., of Brooklyn, N. Y., Demonstrator of Anatomy, Long Island College Hospital. Philadelphia: Printed by William J. Dornan, 1893.

This essay was called forth by the offer of Dr. George M. Gould (already noticed by us) of a prize of $100 for the best essay sent him upon this subject. Copies may be obtained at the rate of seventy-five cents a dozen from Dr. Geo. M. Gould, 119 17th St., Philadelphia. We will perhaps comment upon its contents in a future issue of the Journal.

Bloodless Amputation at the Hip-Joint by a New Method; by Nicholas Senn, M. D., Professor of Surgery, Rush Medical College, Chicago. Reprint from *Chicago Clinical Review,* February, 1893.

Medical Department of the University of Wooster. Announcement for 1893. This three-year school is located in Cleveland, Ohio.

Healing under a Moist Blood-Clot in Accidental Wounds; by ROBERT W. JOHNSON, M. D , Professor of Principles and Practice of Surgery in the Baltimore Medical College. Reprint from *Annals of Surgery*, March, 1893.

This paper was read before the Clinical Society of Maryland, January 20, 1893.

The Surgical Care of Workmen; by ROBERT W. JOHNSON, M. D., Professor of Principles and Practice of Surgery in Baltimore Medical College. Reprint from *Medical News*, August 27, 1892.

This paper was read before the Medical and Chirurgical Faculty of Maryland at its annual meeting, April 26, 1892.

The Bicycle in its Relation to the Physician; by SENECA EGBERT, M. D., Lecturer on Hygiene, Drexel Institute, Philadelphia. Reprinted from the *University Medical Magazine*, Nov., 1892.

Gastrostomy in Carcinoma of the Cardiac Orifice; by EMORY LANPHEAR, M. D., of Kansas City, Mo. Surgeon to University Dispensary, etc. Reprint from *Medical News*, October 1, 1892.

Oxygen as a Distinct Remedy for Disease and as a Life-Saving Agent in Extreme Cases; by A. W. CATLIN, M. D., Attending Physician, St. John's Hospital, Brooklyn, N. Y. Reprint from *Brooklyn Medical Journal*, Aug., 1892.

Annual Announcement of Cooper Medical College, San Francisco, Session of 1893; also *Annual Report of Dispensary of Same for* 1892.

Cholesteatoma of the Ear: by HARRY FRIEDENWALD, M. D., Lecturer on Ophthalmology and Otology, College of Physicians and Surgeons, Baltimore. Reprint from *Medical News*, March 11th.

We have recently received the first issue of a new German journal entitled "*Gesundheitsrat,*" published in Stuttgart. It is an attractive bi-weekly sheet devoted to hygiene, massage, etc.

Medical Progress.

DIRECTIONS IN TYPHOID FEVER.

Dr. Wible, of Allegheny Co., Pa., states, in a recent article upon thymol in typhoid fever, that he is accustomed to give his nurses the following printed directions concerning the treatment of typhoid fever patients:

1. Give each patient five grains of thymol every three hours.
2. Give ten grains of the salicylate of bismuth every three hours when there are more than three to four stools in twenty-four hours.
3. Give each patient two quarts of skimmed milk every twenty-four hours.
4. Give cracked ice and ice-water freely, allowing from three to eight quarts in twenty-four hours.
5. If the diarrhœa is not marked, beef-tea or chicken-broth may be given once or twice a day.
6. If the diarrhœa is excessive, give nothing but milk and water.
7. When the patient's temperature rises to or above 103 degrees give sponge baths every half hour or apply the cold wet pack until the temperature is reduced below 103 degrees.
8. For abdominal pain or tympanites apply turpentine stupes.

9. Cleanse and disinfect the mouth with a solution of boric acid.

10. Disinfect the stools and urine with a thick solution of the chloride of lime or a five per cent, solution of carbolic acid.

11. Give no solid food until the evening temperature has been normal for ten days.

12. Patients may be allowed to sit up for a short time about the end of the first week of convalescence.

HOW PILLS ARE CHANGED BY LIGHT, AND HOW TO KEEP THEM.

Mr. A. C. Zeig has some ideas on the storing of pills, and recently he gave the *Pacific Druggist* the benefit of them. Mr. Zeig, quite properly, points to the fact that pills are often kept for a considerable time, and that the druggist is apt to forget that meanwhile the ingredients of the pills may be changing and their therapeutic properties deteriorating. "A perfect coating," he says, "materially assists in keeping the mass in its proper state of preservation. The use of amber instead of flint glass bottles, for storing pills, is to be preferred should they be exposed to light; a wrapper or carton accomplishes the same object."

Among gelatine coated pills most sensitive to light the following may be enumerated:

Mercury protoiodide pills, changing from a yellow or light green to a greyish, and sometimes to a dark, color, due to a partial decomposition of the protoiodide with separation of metallic mercury in a finely divided condition, this change being accelerated in presence of moisture.

Phosphorus pills assume a reddish-brown color, due to transformation of the phosphorus into the inactive amorphous variety.

Pills containing ferrous iron undergo oxidation with a noticeable change in color, indicating an approach to the ferric condition.

Quinine pills and white pills generally, on long exposure to light, in the course of time assume a light-brown color due to oxidation of traces of iron naturally present in the gelatin employed for coating.

Santonin pills change in color from white to a dull yellow, resembling picric acid.

Pills containing silver salts are naturally very sensitive to light, making the best possible protection necessary.

Calomel pills of a greyish color or dark color are sometimes met with in the market. While this change from a natural white to a dark appearance may frequently be attributed to the effect of bright light, causing partial decomposition and separation of finely divided metallic mercury, it is more frequently due to the presence of sulphites in the gelatin used for coating, being employed by manufacturers of gelatin for the purpose of bleaching it. A careful selection of the gelatin employed for coating is therefore necessary.

The pills generally effected by an abnormally high temperature and atmospheric changes are such as embody either hygroscopic or resinous ingredients, or which, from the nature of the constituents, are quite soft, as is often the case with pills containing soap. Especially when moist air has access to them, the influence of heat from various sources, whether produced by radiation from a stove or by being in too close proximity to a lamp or gas flame, often facilitates undesirable changes in the ingredients of the mass and coating, thus causing the mass to stain through the sugar coating, or causing it to sprout, as is sometimes the case with gelatin-coated pills, rendering the coating itself more or less adhesive.

Pills containing hygroscopic ingredients—such as potassium iodide, potassium carbonate, etc.—require the closest attention in order to insure their proper

preservation. By storage in bottles tightly corked, remote from any source of heat, preferably in a place where the variations in temperature are not too pronounced, any difficulties of this nature may be avoided.—*Bulletin of Pharmacy.*

EPILEPTIC COLONY.

The State Board of Charities of New York recommends that the epileptic colony which the State has decided to erect shall be located in Livingston County, and be known as the Sonyea Colony, after the religious community which now occupies the site of the proposed colony.

In Massachusetts a small institution for the separate care of epileptics has been in operation for some time. Ohio has well under way at Gallipolis, buildings for a colony of epileptics in that State. It will thus be seen that the principle of separate provision for epileptics has gained a foothold in this country. With the Ohio and New York colonies in successful operation, no doubt other States will be moved to make similar provisions. This colony plan of caring for epileptics has long been in favor in Europe, especially in Germany; the Bielefeld Colony in its workings having been well described by Dr. F. Peterson, of New York, to whom, perhaps, more than any one else, is due the honor of having the colony plan for epileptics introduced in this country. These colonies consist of a large number of buildings which permit of a considerable classification of patients, and afford opportunities for labor suited to the capabilities of all who are able to perform any sort of work. The essential idea of the colony plan is to care for epileptics in a manner strongly suggestive of an ordinary village life, at the same time to have them under competent medical care. The huge "institutional" building, an eighth of a mile long and four stories in height, which is now so deservedly becoming unpopular, does not figure in the ideal epileptic colony.

When the peculiar misfortune of epileptics and the perplexing difficulties in caring for them either in asylums or general hospitals is considered, the developing colony system will be looked forward to as a most humane solution of a most difficult problem.

It would doubtless be well for Pennsylvania to follow where Ohio and New York have led. In a paper read before the State Society at Harrisburg last May, Dr. Diller, of this city, urged the Society to petition the Legislature in the matter. Nothing was done at that time, but it is understood that it is to be brought forward at the meeting of the Society this year again.—*Pittsburg Medical Review.*

EXPERT FEES.

Dr. E. C. Quimby, of Titusville, Pa., was the defendant in our court this week in a suit for malpractice, in treating an injury to the elbow-joint, involving a fracture of the neck of the radius and of the olecranon process. The verdict was in the doctor's favor. Among the witnesses was Dr. Theo. J. Young, of Titusville, produced by the plaintiff as a medical expert. After the doctor had answered the preliminary questions, as to his graduation, length of time in practice, etc., the plaintiff's attorney requested him to examine the young man's arm and state to the court and jury his opinion of the case. Dr. Young promptly answered, "I decline to examine the arm." The attorney was a trifle surprised, and told the doctor that he could retire. As he was leaving the witness stand the lawer said: "Doctor, will you give to the court your reasons for declining to examine this arm?" He replied: "Mr. Richmond, I have been called in this case as an expert, I have given years of hard study to acquire my medicalknowledge, and have spent much money, and I decline to be brought here to give testimony as an

expert without an expert's fee." The doctor then left the court-room.—Correspondence of *Pittsburg Medical Review.*

MOVABLE KIDNEY.

In an elaborate article upon this important subject (*Amer. Jour. Med. Science,* April), Dr. Edebohls gives the following summary of his investigations:

Atrophy or absorption of the peri-renal fat is the chief etiological factor in the production of movable kidney. Other causes assigned by various authors are: tight lacing, laxity of abdominal walls, congenital predisposition, and severe straining.

A distinction should be maintained between movable and floating kidney.

A movable kidney is one movable within a pouch or hollow formed within its own fatty capsule. A floating kidney has normal relations with that portion of its fatty capsule which it carries with it in its excursions, and is supplied with a mesonephron, the length of which determines the degree of mobility. This paper deals only with the movable kidney.

The symptoms are likely to be more distressing in the earlier than in the final stages of movable kidney.

The most characteristic combination of symptoms of uncomplicated movable kidney is the following: Digestive disturbances, chronic in character; epigastric pain, usually located somewhat to the left of the median line; general nervousness; cardiac palpitation; inability to feel comfortable, or to sleep, when lying on the left side.

The other symptoms associated with movable kidney occur less frequently and are of secondary significance.

The symptoms of movable kidney are accentuated during menstruation and the early months of pregnancy. They disappear during the latter half of pregnancy and during the existence of large intra-abdominal growths.

The symptoms of movable kidney are due to pressure and traction upon, stretching, and irritation of various parts of the solar plexus of the sympathetic and of its branches. The theory of obliteration of the lumen of the duodenum, by pressure or traction, is insufficient to account for the symptoms.

A movable kidney is the easiest of all intra-abdominal conditions to diagnosticate. The diagnosis is made by palpation of the displaced organ.

A kidney once movable never again becomes firmly fastened in its normal position except by operative interference.

The symptoms due to movable kidney may be ameliorated by the dorsal decubitus, the Weir Mitchell treatment, massage, electricity, and abdominal supporters. All of these measures are, however, in the large majority of cases disappointing, and the benefit obtained, if any, is likely to prove only transient.

Nephrectomy, or extirpation of the movable kidney, is too radical and dangerous a resource as compared with nephrorrhaphy.

Nephrorrhaphy *properly* performed upon properly selected cases can, as demonstrated by appended histories, be depended upon to afford relief, with a good prospect of the permanency of the latter.

A CASE OF SYMPHYSIOTOMY.

Hannah P., primipara, aged twenty-seven, was admitted to the Emergency Hospital at 9 A. M., January 8, 1893. She had then been in labor about twenty-two hours. From her husband it was learned that she had been attended at her home by a physician since 4 A. M. The latter had unsuccessfully tried to perform version, and about three hours previous to her coming to the hospital he had caused her to be placed under chloroform and had applied forceps.

At the time of her admission the patient was in a somewhat exhausted condition. Her pulse was 130. The labor pains were frequent but cramp-like in character. An examination showed a very œdematous condition of the vulva, a perineum torn through to the rectum, and the anterior vaginal wall badly lacerated. The laceration of the cervix extended above the vaginal junction. On introduction of the catheter a small quantity of bloody urine was withdrawn.

Axis-traction forceps were at first applied to the head, but without success. I was summoned near midnight. At that time the pulse was 150, and feeble. I found a brow presentation. Owing to the firm retraction of the uterus, version was impossible. I feared to resort to craniotomy and the cranioclast, as the injuries already inflicted upon the soft parts seemed to preclude a lengthy operation and one always accompanied by contusion. I therefore decided to resort to symphysiotomy, hoping by so doing to correct without violence the faulty presentation. The operation was performed by means of the Harris-Galbiati knife. The separation of the symphysis was accomplished without difficulty. Two assistants were employed to exercise pressure upon the hips to prevent excessive divergence of the pubic bones. As was anticipated, the conversion of the brow into a vertex presentation was easily effected by the hand. Forceps were then applied to the head, and the extraction of the child followed with little delay.

The cut surfaces of the symphysis were then brought together, and the ligaments were sutured with catgut. The wound in the soft parts was stitched with No. 12 silk. A wide strip of adhesive plaster was passed around the hips and fastened across the pubes in front, and a firm bandage was adjusted. The patient rallied fairly well, but about 7 A. M. went into a collapse and died at five in the afternoon.

The child was born alive; it weighed nine pounds; the head had been much injured by forceps, and the lower jaw was fractured, apparently from attempts to convert the brow into a face presentation. Death took place at the end of seventeen hours.

No autopsy was permitted in the case of the mother; the bandage and adhesive strap were, however, removed after death, and a careful examination of the pubic wound was made, both externally and *per vaginam*. It can be safely asserted that the symphysiotomy was in no way chargeable with the fatal issue.—Dr. Lusk, *Amer. Jour. Med. Sci.*, April.

A PLANT TO SUPPRESS MALARIA.

Dr. Brandes, of Hanover, calls attention to the properties of the *Anarcharis alsinastrum*, a water plant which has hitherto been considered an unmitigated plague, choking up rivers, and altogether useless. He has remarked that in the district where he lives, and where malaria and diarrhœa yearly appeared in a sporadic or epidemic form, these diseases have gradually decreased since the *Anacharis alsinastrum* began to infest the neighboring rivers and marshes, and since four years have toally disappeared. The above-named water plant nourishes itself on decayed vegetable matter, and grows with incredible rapidity. It thus destroys the germs which produce malaria and diarrhœa; and besides, its presence obliges the frequent cleansing of standing waters—a measure beneficial to health. Dr. Brandes therefore proposes that the experiment should be tried of planting the Anacharis in the marshy districts. It is also useful in protecting the young fish, and affords an excellent fertilizer. The plant came originally from Canada, whence it was taken to England, and thence to Germany about 1840.—*Druggist's Circular*, March, 1893.

THE NURSING OF FOUNDLINGS.

In a recent number of the official organ of the Medical Association of Lombardy, Dr. E. Grassi reports the result of a "new departure" in the nursing of foundlings, made by him about a year ago in the Foundling Hospital at Milan. Being dissatisfied with the results of mercenary nursing and artificial lactation, it occured to him to appeal to the mothers of the foundlings to act as wet nurses to their own offspring, strict secrecy being preserved as to the real relations between them. Between January 19th and June 23rd the appeal was responded to by 42 mothers out of a total number of 442, a proportion higher than Dr. Grassi had dared hoped for. By repeated personal visits he was able to satisfy himself of the excellent physical and moral effects, both to mother and child, of the experiment. The children were, without exception, in far better condition than those put out to hired nurses. While the death-rate among the nurslings entrusted to the latter was nearly 26 per cent., in the first month of life not one of the 42 babes nursed by their own mothers has yet died. Dr. Grassi believes that the number of mothers of illegitimate children who will undertake the nursing of their own offspring, under the supervision of the Foundling Hospital will steadily increase, and he insists on the immense advantage of such an arrangement to the poor little waifs themselves.—*Ex.*

THE TREATMENT OF CHOLERA.

The *Gazette des hôpitaux* for February 25th contains a cyclopædic article on this subject by one of the hospital physicians of Paris, Dr. L. Galliard. Summarizing, in conclusion, he says that in slight cases of *cholêra léger*, rest in bed and abstinence from solid food are almost all that is required. In grave cases, however, the precursory diarrhœa should be treated energetically. If this diarrhœa can not be cut short, no time should be wasted in trying opium or such feeble antiseptics as the salts of bismuth, for example, but recourse should be had at once to one of the two remedies which commend themselves to our confidence. These are calomel and lactic acid. They should not both be used, but one or the other be chosen. If it is calomel, acid drinks are to be avoided. If there is a tendency to collapse and cyanosis, hot baths are to be employed, together with friction, subcutaneous injections of ether and caffeine, and inhalations of oxygen. If there is algid collapse, with the radial pulse imperceptible, transfusion should be used. The proper drinks are iced aerated waters, champagne diluted with water and ice and very weak iced coffee. Neither milk, nor soup, nor alcohol should be given before the stage of reaction. Tea often causes vomiting. If the use of milk and other alimentary substances is allowed too soon, the danger of relapse is incurred. The use of ass's milk is of service in the gastric irritability of convalescents; so is that of peptonized enemata. In spite of their impatience, convalescents must be kept in bed for a long time.—*N. Y. Medical Journal.*

PERIPLEURITIS.

This term is used to indicate an affection whose chief feature is suppurative cellulitis of the thoracic wall; extending perhaps down as far as the connective tissue of the loins or abdomen. We clip some facts concerning it from an article by Dr. Blaikie Smith, of Aberdeen, in the *British Medical Journal*, February 18th. He says:

The uncomplicated form of the disease may be confounded in the early stage with acute pleurisy. From this complaint it is to be distinguished by the presence of an extraordinary degree of local hyperæsthesia, and of pain on mov-

ing the arm of the affected side. The rapid occurrence of suppuration, together with the absence of friction, etc., will also afford valuable diagnostic aid. But when the case is seen at a later stage, the obstacles in the way of an accurate diagnosis are far more formidable. The chief difficulty is with empyema. With an ordinary empyema there is not much chance of error, but it is otherwise with the rarer forms of that complaint. When empyema is of the perforating variety (the so-called empyema of necessity), the resemblance between the two diseases is often very remarkable. They may generally be distinguished, however, by attention to the following points:

1. Peripleuritic abscesses are unattended by signs indicating displacement of organs.

2. They are more frequently multiple than abscesses having a connection with the pleural cavity.

3. They do not pulsate (as is often the case with perforating empyema), they are not capable of being diminished by pressure, nor do they as a rule communicate with each other.

4. Their size is not generally influenced by the respiratory movements. Bartels, however, states that peripleuritic abscesses do occasionally vary with respiration, increasing with expiration, and decreasing with inspiration, but these phenomena are much more likely to be witnessed in perforating empyema than in abscesses whose origin and situation are extrapleural. In my own case they were absent. Bartels also mentions that the specific gravity of peripleuritic abscesses is about 1040, while that of purulent collections originating in the pleural cavity ranges from 1028 to 1032.

5. In peripleuritis the boundaries of the lungs are observed to increase with a full inspiration, and areas presenting normal physical signs may be discovered between or below the different abscesses.

6. Lastly, the diagnosis of peripleuritis will be supported by the appearance of suppuration in the loins or abdomen, and the presence of enlarged glands in the axilla of the affected side.

In some very rare instances a perforating empyema loses its connection with the pleural cavity, and becomes encapsuled in the thoracic wall, thus presenting signs that are almost identical with those of abscesses of peripleuritic origin. In arriving at a diagnosis in such cases, reliance must be placed chiefly on the clinical history; at the same time Bartel's observation as to the different densities of extra- and intra-pleural suppuration may afford a certain amount of diagnostic aid.

The only other complaints likely to be confounded with peripleuritic abscesses are caries of the ribs, resulting in the formation of pus, and actinomycosis. In the former affection the probe will discover the existence of diseased bone, while in the latter the microscope will reveal the presence of the characteristically shaped ray fungus on which the disease depends.

Prognosis.—Simple cases generally terminate favorably, but when complications exist the result is much more uncertain. Many cases end fatally from pleurisy, while others succumb to pericarditis, peritonitis, acute nephritis, or to pyæmia.

The *treatment* of peripleuritis is mainly surgical, and is therefore considered to be beyond the scope of the present paper.

CAUTION RESPECTING SULPHATE OF COPPER IN GYNÆCOLOGY.

Sulphate of copper has been strongly recommended as a local application in endometritis by Dr. Dumontpallier, who believes that it is superior to chloride of

zinc, as it only produces superficial cauterization, and according to him has no tendency to cause ultimate atresia of the os. He employs an elongated suppository made of equal parts of sulphate of copper and oatmeal. According to M. Matignon, who recently read a paper on the subject before the Bordeaux Medical Society, sulphate of copper is by no means always so mild in its action as Dr. Dumontpallier believes. In one of his cases, where a suppository containing seven grains and a half of the copper salt was inserted, the patient experienced four days afterwards severe uterine colic and vomiting; a quantity of false membrane was passed, in which microscopical examination showed all the elements of the uterine mucous membrane, together with those of the subjacent muscular tissue. This was followed by a very perceptible diminution in the size of the cervical canal and also by a severe imflammatory attack in the uterine appendages. In two other cases where similar treatment was employed there was evidence of the caustic having destroyed the whole thickness of the mucous membrane and part of the muscular coat, some degree of atresia following. Notwithstanding these occasional inconveniences, M. Matignon does not suggest that sulphate of copper should be abandoned, as he finds it most useful in leucorrhœa, but he says that not more than three grains and a quarter should be used in the suppository.—*Lancet.*

CYANIDES AS DISINFECTANTS.

Tho following is extracted from an article by Sir Joseph Lister in the *British Medical Journal,* February 18: An external antiseptic dressing, to be ideally perfect, should have four essential qualities. It should contain some thoroughly trustworthy antiseptic ingredient; it should have that substance so stored up that it cannot be dissipated to a dangerous degree before the dressing is changed; it should be entirely unirritating; and it should be capable of freely absorbing any blood and serum that may ooze from the wound.

The agent which we have found most satisfactory as the antiseptic ingredient of the dressing is the double cyanide of mercury and zinc. Cyanide of mercury, while it has powerful antiseptic properties, is very soluble and highly irritating; but the combination of cyanide of zinc with it has the same sort of effect, but in a much higher degree, as the albumen of the sero-sublimate gauze had upon the bichloride. The combination with zinc keeps the cyanide of mercury from being dissolved away, and also prevents it from irritating. It is, so to speak, chained down by the cyanide of zinc with which it is combined. The double salt is very little soluble in blood serum, requiring between two and three thousand parts to dissolve it; and thus a small quantity of it will last a long time in spite of a free flow of discharge through it. It thus fulfils the condition of persistent storage. It is at the same time practically unirritating; wounds heal under its immediate contact without the necessity for a protective layer interposed. Then, as to the essential question of its antiseptic virtues. Small as is the quantity which serum dissolves, it proves amply sufficient to prevent bacteric development. Thus in one experiment some serum of horse's blood containing 1-5000 part of the salt remained clear and odorless for more than a fortnight at the temperature of the body in spite of inoculation with putrid material, and even 1-10000 part prevented all growth for ten days. When mixed with serum and corpuscles, it prevents putrefaction in smaller quantity than any other antiseptic with which I am acquainted. The greater the amount of albuminoid substances in any solution, the more severely is the antiseptic tested; and when the red corpuscles are mingled with the serum, as is the case in the first twenty-four hours after the infliction of a wound, a much larger amount of the anti-

septic is needed than with serum only. Thus four times as much corrosive sublimate is required to prevent putrefaction in serum and corpuscles than in serum. Now, the double cyanide answers the purpose in half the quantity that is necessary with corrosive sublimate. As an illustration of the practical value of this material, I may mention a single experiment, not hitherto published. I packed a piece of glass tube with gauze charged with 3 per cent. of the double salt, and poured into it serum and corpuscles obtained by whipping pig's blood. I then inoculated one end of the saturated gauze with a drop of septic serum, and kept it at the temperature of the body, with provision for preventing evaporation. After the lapse of five days I found the entire mass of gauze pure in odor and without bacteric development, as tested by microscopic examination of stained cover-glass preparations of the contained blood. Meanwhile a piece of unprepared gauze similarly treated showed bacteric development within twenty-four hours.

But here I must remind you of the essential difference, which must always be kept in view in considering antiseptic agents, between germicidal and inhibitory power; that is to say, between the capability of destroying the life of microbes and that of preventing the growth while the agent remains in contact with them. These two properties are by no means similarly proportioned to each other in all antiseptics. Thus, cyanide of mercury is far superior to the bichloride in inhibitory power, but very inferior to it as a germicide. And the double cyanide of mercury and zinc, while admirable as an inhibitor, is very feeble as a germicide; so that we can have no security that materials charged with it may not contain living organisms. Hence if gauze charged with the double cyanide were applied dry to a wound, the time might come when, if the discharge was free, the salt, in spite of its slight solubility, might be all washed out of the deepest parts of the dressing; and as soon as this should be the case, living microbes contained in it would be free to develop towards the wound. In order to guard against this risk, we treat the gauze before using it with a reliable germicide. That which we now use for the purpose is the 1 to 20 solution of carbolic acid, which, besides being thoroughly effective, has the further advantage that it soon flies off from the dressing and leaves nothing in contact with the wound but the unirritating double cyanide and cotton fabric.

And now I wish to correct a mistake I made in a former publication. For the purpose of destroying any microbes that there might be in the gauze I recommended a solution of corrosive sublimate, 1 to 4,000. Now we have seen that the 1 to 4,000 sublimate lotion is not nearly so powerful as a germicide, as we then supposed. But it futhers appears that such power as it possesses is almost entirely lost as soon as the bichloride comes in contact with the cyanide of mercury and zinc, when a curious soluble triple compound is formed which has extremely slight germicidal action. The triple salt seems also to be highly irritating; and thus, when we use the bichloride of mercury, we fail almost entirely to obtain the object for which we employed it, and at the same time lost some of the goodness of the double cyanide, part of which was washed out during the process, while the resulting solution might cause troublesome irritation. Soon after I first described this dressing, a surgeon at one of our hospitals came to me and said he had been using it, and found great inconvienience from it. He had applied it to a scalp wound, and the whole of the skin covered by the dressing was excoriated. I found he had applied it soaking wet with bichloride lotion, and we are now able to understand the irritation that resulted.

GENERALIZED VACCINIA.

At a recent session of the London Clinical Society (*British Medical Journal*), Dr. Colcott Fox read notes of two cases of generalized vaccinia. In both the infant was the only one thus affected out of many vaccinated from the same source. In each case a primary vaccination ran a normal course, and about the ninth day the vaccinated arm became covered with a dense aggregation of supplementary vesicles. These were quickly followed by others disseminated singly or in twos and threes over the unbroken skin of the scalp, face, trunk (front and back), and limbs. Fresh lesions were evolved for two or three days, and then abortive pustular lesions till the twenty-fifth day in first case, and till the eighteenth day in second case. Hardly any scarring resulted, and the mucous membranes were free. Dr. Fox then referred to the literature of the subject, and discussed the arguments for and against the theories of a spontaneous evolution or auto-inoculation. The latter could not probably be absolutely excluded as a possible cause in any case, though there were obvious difficulties to meet in some cases. On the other hand, there was evidence that a spontaneous eruption was not improbable, as in inoculated variola, and cow-pox was now and again shown to be probably a modified phase of variola, rendered non-infectious to man.

Dr. Acland mentioned the case of an infant, aged three months, vaccinated with humanized lymph, in whom the vaccination ran a normal course until the fourteenth day, when the inoculation wounds coalesced, and several secondary vesicles formed near the primary wounds, followed shortly by others over the whole body, of the diameters ranging from one-sixth to four inches. These continued to appear for six weeks, when death from exhaustion occurred. This was an unusual case of generalized vaccinia. He had traced the lymph through its whole course from the calf, this patient being the forty-fourth remove, and all the cases, excepting one, had run a normal course. None of the covaccinifers had been similarly affected, nor were the children vaccinated from this infant in any way abnormally affected.

The President said that the drawings reminded him of cases he had seen which he considered to be instances of generalized vaccinia. He thought auto-infection must play a large part in the production of these unusual complications. One might expect generalized vaccinia to be more common since calf lymph, which caused more severe action, had been more frequently used, and he asked if this had been noticed.

Dr. Chapman, who always used calf lymph, had not observed that its effects were in any way more severe than those produced by humanized lymph. He thought the vesicles should be left intact; if opened they became irritated, if left alone they soon withered away.

Dr. Barlow remarked on the rarity of these, cases which were quite distinct from impetigo contagiosa, which was not rarely a sequel of vaccination. In Mr. Hutchinson's paper on Vaccinia Gangrenosa was another example of generalized vaccinia. In that case auto-infection had not occurred, whereas in the two cases recorded that evening it afforded a possible explanation. After vaccination with calf lymph a papular eruption often appeared on the extremities about the eleventh day, causing little or no irritation, and easily overlooked. That eruption he considered to be a rudimentary manifestation of generalized vaccinia: This unfortunate complication was of extreme rarity, so that, although disastrous when it occurred, it had no appreciable bearing on the general question of vaccination.

Dr. A. T. Longhurst also doubted if calf lymph gave more severe results than

humanized lymph. Local trouble he considered due to the coalescence of the inoculations, and obviated them by making two inoculations on each arm, never four on one arm.

Dr. Fox, in reply, said that in one case there was auto-inoculation and communication also to the mother, probably through sleeping with the child. He believed generalized vaccinia to be less common than was usually supposed. Public vaccinators never saw these rashes, as they did not develop until after the eighth day. Vaccination ought not, therefore, to be considered complete until the sores had disappeared, and until then the children should be kept under observation by the vaccinator. The children should, as formerly, be examined at any rate on the twelfth day.

THE ICE-BAG IN PERICARDITIS.

An interesting paper upon this important subject was read recently by Dr. Lees before the British Association (*Brit. Med. Jour.*, February 18). He includes reports of seven cases, four of them in children, in which it was tried. We regret that the reports are too long for quotation.

Dr. Lees began his paper by drawing attention to the serious consequences, in damage to the cardiac muscle and the formation of adhesions, which too often resulted from a pericarditis after apparent recovery. He pointed out that the present treatment of pericarditis was not merely practically *nil*, but that it was not seldom actually a minus quantity, for the occurrence of this complication often induced the physician to give up the use of salicylates on account of the supposed danger of their employment in this condition. After a considerable experience in the use of ice in the treatment of pneumonia, he had ventured to try it for pericarditis, and with very satisfactory results. It is clear that if the local application of ice has any influence in checking the subjacent inflammation, in so far it will tend to relieve the heart from depression, and thus act as a true cardiac tonic. Whether it does this or not can only be discovered by cautious employment of the ice-bag, and careful observation of the result.

In the first case, rheumatic, the ice-bag gave great relief, and he thinks it certainly had no harmful influence. In the second, from influenza, both pericarditis and pleurisy subsided without effusion. In another case a pericardial effusion was rapidly absorbed under the ice-bag. In some of the cases salicylates were used, in others they were not used. In closing, Dr. Lees says:

It so happens that during the last six months I have not had the opportunity of treating any other cases. But what I have narrated is sufficient, I think, to prove that the ice-bag, when used with reasonable caution, is a safe application in pericarditis, that it is usually liked by the patient, that it tends to check the violence of the local inflammation and to hinder effusion, and that it may even help to cause absorption of effusion which is already present. It acts *cito, tuto, et jucunde.* In view of the extreme importance of preventing, if possible, damage to the structure of the heart, I believe that the introduction of the ice-bag into the treatment of pericarditis will be found a great advance in therapeutics.

PHYSIOLOGICAL STYPTICS.

In the *Lancet*, February 25, Dr. Wright writes as follow upon this theme:

In the *Brit. Med. Jour.*, December 19, 1891, I suggested that the knowledge of the processes of coagulation, which had been acquired by research, might probably be turned to account in providing the surgeon with a physiological styptic. I pointed out that such a physiological styptic would be absolutely painless in application, since it would exert an elective influence on the blood and would be

inert with respect to every other tissue. It would thus differ altogether from our ordinary styptics, which owe their hæmostatic power solely to the formation of an eschar by the destruction of surrounding tissues. Escharotic styptics would appear to be anachronisms in a civilized system of therapeutics. In the communication referred to above I suggested for employment a styptic consisting of a "solution of fibrin-ferment," which had received an addition of calcium chloride. I do not propose to add anything here to what I have already said with regard to this styptic, for I find that a styptic of much greater coagulative power can be prepared as follows:—

Preparation of the proposed styptic.—Take the thymus gland (chest sweetbread) of a calf, reduce it to a fine pulp by passing it through a sausage machine, and extract with three or four litres of a 1 to 2 per 1000 solution of carbonate of soda which has received an addition of five grammes of chloroform per litre. Stir thoroughly at intervals and continue the extraction for twenty-four to thirty-six hours. At the expiration of that period it will be found that almost the entire substance of the gland has dissolved in the dilute alkaline fluid. Strain through fine calico and add 1 per cent. of calcium chloride; preserve in stoppered bottles. This styptic will keep for an indefinite time if the chloroform is prevented from evaporating. With a styptic prepared as above I have been able to arrest the hæmorrhage after cutting across both a femoral and a carotid artery in a dog. The action of the styptic was assisted by compressing the arteries for one or two minutes.

Therapeutic employment of the above styptic.—The styptic may be applied on a tampon to any bleeding surface where strict asepsis can be dispensed with. If it is necessary to render the styptic perfectly aseptic, this can be done by boiling after making a sufficient addition of alkali to keep the albuminous substances in solution. Boiling involves a great, but not a complete, loss of coagulating power.

In conclusion, I need not do more than merely advert to the fact that the proposed styptic consists of a solution of Wooldridge's "tissue" or "cell-fibrinogen" with an appropriate addition of lime. If this styptic is found to be of practical utility it is to be remembered that this is entirely due to the researches of Woodridge in this country and Arthus and Pagès in France. The cost of production of the styptic may be put down at something less than 1*s.* a litre.

A NEW PHILOSOPHIC METHOD IN THERAPEUTICS.

In the *N. O. Med. & Surg. Jour.*, March, the editor comments upon a new departure in therapeutics indicated by an article quoted from the *Centralblatt für Chirurgie.*

A certain Mons. Carreau saw a leprous patient bitten by a rattlesnake, and observed a marked diminution in the size of the tubercles twenty-four hours after the bite. The inoculation of a serpent poison produces a condition of methæmoglobinæmia, indicated by black fluid blood, jaundice, and internal and external hæmorrhages. Recognizing this fact, M. Carreau resolved to produce this condition by a medicinal agent, and he accordingly gave to a leprous patient very large doses of chlorate of potash. He gave from 150 to 300 grains of the drug daily for three days, producing grave symptoms; but when the poisonous symptoms subsided, the leprous tubercles almost entirely disappeared, leaving the skin soft and wrinkled. This seems rather heroic, but it opens up a vista of possible future uses of this remedy in other diseases due to microbes, as well as hopeful with regard to leprosy itself.

Carreau's experience recalls the attempts of Unna, of Hamburg, to cure leprosy with ichthyol and resorcin. In a series of *Dermatologische Studien* he

dilated upon the value of the two remedies just mentioned as reducing agents—they are greedy for oxygen. The bacillus of leprosy is aërobic, and oxygen is as necessary to its existence as to ours. By cutting off the supply of oxygen locally, Unna hoped to destroy the bacillus in the affected spots. He used strong ointments and solutions of the remedies, and the results that he reported showed that the leprous processes had been modified at least. By administering overwhelming doses of chlorate of potash, Carreau produces a condition of methæmoglobinæmia, in which the blood refuses to give up readily its oxygen to the tissues; so here we have a general deficiency of oxygen instead of a local one. The result, as far as the bacilli are concerned, is the same. They perish (or become quiescent) from want of oxygen. If it should so be that the system of the patient can stand the lack of oxygen better than the bacilli, then the therapeutist will only have to produce gradually a condition of asphyxia and let the bacilli and the patient fight it out on that line. If the bacilli can manage to get along without oxygen for a while, so much the worse for the patient.

A NEW METHOD OF MANIPULATION FOR THE REPLACEMENT OF THE LOWER JAW WHEN DISPLACED.

The patient is seated in an ordinary cane-bottomed chair; the operator stands before him with one foot placed slightly to the right side and the other just in front of the patient and in the middle line. The operator is thus on a firm basis with the legs well apart and fully extended. He then flexes himself at the hips and asks the patient to lean forwards and to place his forehead in the middle of the sternum of the operator's chest (but this position varies with the size of the patient's head). The operator now flexes his head so that his chin grips the patient's head about the upper part of the occipital bone; he thus acquires a firm hold and has the head well under control between his chin and chest. The thumbs, protected in the usual manner, are placed in the patient's mouth and the fingers of both hands grasp the lower jaw. In this position reduction is facilitated, and the advantages over the ordinary methods are as follows: (1) The operator has the head under perfect control and perfectly fixed; (2) the line of force exerted by the operator's hands acts in the same line as the resisting force exerted by the operator's chin; (3) the operator's elbows being well flexed, he can exert a greater power by the force acting through the thumbs being close to the shoulders, and it will be found that he has greater power of muscular action in the terminal phalanges of the same; (4) the patient's head is also in a better position for replacing a dislocated jaw; (5) the operator needs no assistant and does not inconvenience his patient by the excessive pushing and pulling about of the head during the reduction.—Dr. Roth, *Lancet*.

Recommendations of Therapeutic Agents.

Losophan in dermatology.—Losophan (or triiodocresol) has certain definite indications in dermatological practice which specially commend it to physicians. For instance—as stated by several recent observers—it has proved to be of the highest value in mycosis microspora, or facial mycosis tonsurans, in which it gave prompt and decided cures. In folliculties barbæ, or sycosis vulgaris, losophan in one per cent. ointment, or solution, gave excellent results. In some cases two and three per cent. compounds were employed to advantage. Some of the cases which were said to have long resisted other treatment, were cured in from eighteen

to twenty days. The remedy is an energetic stimulant, but does not irritate except the quantity used be too large. In some cases where the remedy was discontinued on account of the irritation produced, it was found later, when weaker applications were employed, that the lesions got well. In pityriasis versicolor complete cures were made with a few applications with a brush, of one and two per cent. solutions. The same results are reported from the use of losophan in eczema siccum. In some cases of papular eczema also, the result was most gratifying. It was found that losophan is the best remedy we have for prurigo, and it either cured, or greatly relieved all cases. In scabies, losophan acts more promptly than the usual remedies. It was used in two to three per cent. ointment. Pediculosis capitis and pubis were cured by one per cent. solutions of losophan, to which twenty-five per cent. of vinegar was added. It is thought that this remedy will be of exceptional value in the dermatoses determined by epizoa.

Medical Items.

Dr. W. Guy Townsend has removed his offices and residence from 412 West Biddle St., to 1918 N. Charles St.

Dr. Edward A. Smith, of this city, was married April 4th, in St. Luke's P. E. Church. He will occupy his new offices and residence at 2505 Pennsylvania Ave.

Some interesting scientific advances are given in an editorial of the Baltimore *Sun* in the line of obtaining light in as pure and independent condition as possible.

We are warned by an article from the pen of Dr. Dock, in the *Medical News* of March 25th, that caution must be used in prescribing suppositories for gonorrhœal patients; since the rectum may become infected during the necessary manipulations.

The efforts of the friends of Dr. Sims to erect a statue to his memory in New York are about to be crowned with success. The sculptor is Von Miller, of Munich, and it is stated that he has not only succeeding in making a life-like picture of the distinguished gynæcologist, but has given an artistic grace to the pose which will challenge criticism. The pedestal will be of granite, eight feet in height; and the statue is in bronze, nine feet in height.—*Ex.*

The eleventh annual meeting of the American Medical Editors' Association will be held in Milwaukee, Wis., June 5, 1893. Dr. Ernest Hart, editor of the *British Medical Journal*, will deliver the annual address. This will be followed by other addresses and discussions which promise to be of unusual interest to every editor and medical journal in the country. The price of tickets to the annual banquet will be three dollars.

A typhoid fever patient has been taking tabloids of quinine—2 grains in each—three times a day at first, and lately four times. Three days ago I discovered in one stool two tabloids—whole, but slightly enlarged—and I found one and pieces of others each day since. This is the seventeenth day, as far as the data of motion can be fixed, and there has been no diarrhœa, the bowels having acted once each day after an enema.—Dr. Groves, in *Lancet*.

In making a post-mortem examination of a female lunatic who died lately in the Kew Asylum, the doctors found in her internal organs three German silver teaspoons, a piece of iron used to connect the handles of a door lock, and two triangular pieces of glass. The spoons had been missed a month prior to her death. The examination showed that none of these strange articles of diet had anything to do with her death, which was caused by disease of the brain.—*Ex.*

An endeavor is being made to entice Prof. Osler back to Montreal from Johns Hopkins Hospital. At last accounts Dr. Osler's answer was unknown; but we will venture our private opinion that the odds are all against Dr. Osler leaving his present field of work with its magnificent resources and opportunities. At the same time the resources and attractions and powers for splendid work are fast developing at Montreal, and all loyal Canadians will rejoice that this is so, and will congratulate McGill University upon her generous friends and growing power.—*Maritime Med. News.*

We learn through the daily press that Washington is to have a new aid to hygienic enterprise in the "Sanitary League of the District of Columbia," organized recently by Dr. J. S. Billings, R. Ross Perry, Theodore W. Noyes, E. Francis Riggs, John Jay Edson and others. The league is founded on the belief that the neglect of sanitary conditions is the source of great dangers and that many of these dangers might be prevented and much of the evil cured by intelligent, well-directed effort. The object of the league, besides securing the thoroughness of a house-to-house inspection, and improvement in disposal of sewage, is to prevent contamination of the water supplies, and to secure the removal of conditions which would become the source of great danger on the appearance of cholera. The league proposes to do this by disseminating useful knowledge of sanitary matters and domestic hygiene, and by obtaining, as far as possible, the voluntary and continuously active co-operation of intelligent citizens in such a sanitary surveillance of the city as is at present beyond the power of the health office and the District commissioners.

The American Medical Association will meet at Milwaukee, Wisconsin, June 6th, 7th, 8th and 9th, 1893. A preliminary programme of the Section of Neurology and Medical Jurisprudence which has been prepared indicates that the meeting promises to be one of great interest. The first session will be held on the afternoon of June 6th. Two sessions will be held June 7th and 8th, one in the morning, one in the afternoon. The last session will be held on June 9th, morning. Papers will be accepted for the final programme until May 1st, but not later, as all titles must be sent to the Chairman or Secretary in order to allow sufficient time for the preparation of the programmes for the meeting of the entire Association.

The programme says: "If you have not yet indicated your intention to take part, you are earnestly requested to contribute a paper, to present cases, or to exhibit gross or microscopical specimens. It is desired by many of the members of the Section to have a dinner on one of the evenings of the meeting, the subscription to which will be three dollars. If you favor this proposition, please notify the Chairman or Secretary of your willingness to subscribe."

Forty-two papers are announced by full title. The chairman is Dr. Charles K. Mills, 1909 Chestnut St., Philadelphia, Pa.; the Secretary, Dr. James G. Kiernan, 834 Opera House Block, Chicago, Ill.

MARYLAND MEDICAL JOURNAL.

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Original Articles.

HISTORY AND TREATMENT OF A CASE OF EPILEPSY.

BY STEPHEN CROWE, M. D., OF BALTIMORE.

Minnie L., age 19 years, and unmarried, was brought to my office on Sunday, May 8th, last, by her mother, who gave the following history: The girl had always been healthy till after her fifteenth birthday. She had in her childhood all the ailments peculiar to that most interesting period of life; but had overcome them and was considered a strong, healthy girl. When about fifteen and a-half years old she began to complain of a severe pain in the lower part of the stomach (as her mother put it) and a feeling on the head as though some one had placed a heavy weight there. She was given castor oil and other heroic treatment for the troubles, with little effect, as the pain generally lasted about three days and then wore away, the girl being compelled to stay in bed in the meantime. When she was sixteen years old she was taken with fits. These were supposed to be due to the presence of worms, and her mother gave her everything that the wisdom of her neighbors could suggest for the expulsion of the worms. As she grew worse, she was taken to a doctor, who stated she would get all right "when her sickness came on." She was under treatment by the doctor for some time, but got no better, and was taken to a dispensary. Here she was treated for

about six months without deriving any benefit. She had never menstruated and was taken from one doctor to another. Just before her eighteenth birthday, she menstruated for the first time, and the pain she suffered was almost unbearable. She was now having one fit a week. They had increased from one a month to one a week, and when I saw her she was having two a week. I questioned her mother as to her family history and found nothing in it to justify the belief that heredity could be a factor in causing the spasms. There was no history of a fall, or blow on the head. I decided to treat the symptoms as I found them and as she was very much constipated I kept her bowels open with magnesia sulphate, ordered hot vaginal douches, night and morning, and a prescription for grs. xv, kali. brom., t.i.d.

This line of treatment was kept up for two weeks. At the end of that time she came back to say that she felt a little better but had her "spells" just as bad. The same line of treatment was continued for three weeks longer with the same result. About this time I began to feel discouraged, and thought that possibly I was dealing with a case of hysteria instead of epilepsy. As the patient could tell when an attack was coming on, I arranged with her mother to be at the house about the time, and was talking with the family when "she went off." She arose from her chair, wandered aimlessly around the room for some moments, uttered a sharp cry and fell unconscious on the floor, her face as white as though she w s dead. No doubt was in my mind as to the existence of epilepsy after seeing the patient in the attack. The same line of treatment was continued until the latter part of July, when I mentioned to Dr. Robb, of the Johns Hopkins Hospital, the fact of her having such severe pains at her menstrual periods, and asked his advice as to the treatment. I had examined her previously and found that the uterus was in normal position, but very small. Dr. Robb suggested dilating and curetting the uterus and painting the cervix with tr. iodine. Her menstrual periods began about the tenth day of the month and lasted about three days, the discharge being very slight. On August 1st she was anæsthetized and the suggestion of Dr. Robb carried out, a considerable quantity of clotted blood being removed from the womb. She was kept in bed for three days and the vagina packed with iodoform gauze. On August 9th she had a slight spasm which was not as severe as usual. On the 11th she began to menstruate and had no difficulty. The bromide was continued and on August 28th she had another slight attack, making two in the month. The dose of the bromide was now reduced to grs. v. She continued to grow better and did not complain of any abdominal pain or the feeling of weight on the top of the head. On September 10th, menstruated again without any difficulty. September 25th, had another attack. The treatment was continued till October 30th, when the bromide was stopped entirely. She had no trouble in menstruating and has not had any more epileptic attacks. I saw her from time to time until January 1st of this year, when I discharged her, to all intents and purposes cured.

1526 N. Caroline Street.

A CASE OF INCOMPLETE AND IMPERFORATE RECTUM.*

BY SAMUEL T. EARLE, M. D., OF BALTIMORE.

Infant son of Mr. H., four days old, when seen by me September 8, 1892. Was called to the case by Dr. Gibbs, who, together with Dr. N. E. Iglehart, assisted me in the operation which I found necessary to perform. The case was one belonging to the fourth class of such cases as are generally described in the text-books on deformities of the rectum and anus, in which the anus was normal to all appearances, but ended in a blind cul-de-sac, the rectal pouch having failed to descend far enough to meet it, and form the continuous normal canal. The abdomen was very much distended with gas, and the child had refused to eat. Immediate relief was necessary to preserve the life of the child. I had him placed under chloroform and proceeded to search for the deficient rectal pouch by careful dissection from below up into the hollow of the sacrum. I made an incision down through the posterior wall of the anal pouch, and extended the incision on back over the coccyx to the inferior extremity of the sacrum, removed the coccyx, and dissected carefully down in the hollow of the sacrum. After some little delay I found it, recognizing it by the tympanitic note it gave out when hooked up with the tenaculum, a point to which I wish to call particular attention as likely to prove useful in the future to others when making such a search. When found I transfixed it with a ligature and opened it from behind forwards, transversely to the long axis of the rectum. I then drew down the intestine with the ligature and stitched it to the anal opening, closing this wound below with a row of interrupted sutures. As soon as the rectum was opened there was a considerable discharge of meconium with gas, to the immediate relief of the child, who soon began to take his nourishment. It continued to do well up to the fourth day, the last time I saw it, having to leave home. Dr. Gibbs, who was the regular attendant, subsequently told me it gradually failed from that day on until the eleventh day after the operation, when it died. During the whole of that time there were no special symptoms that showed themselves, and as we were unable to make an autopsy, we cannot say positively from what cause it died, although most likely from septicæmia. I should by all means recommend such a procedure as the one described above, in such cases, in preference to the uncertain and dangerous methods formerly in general use, of plunging a trocar through the anal pouch, which, if successful, leaves the patient with a strictured bowel. It is also far preferable to colotomy, which indeed should not even be considered, until the method recommended above has failed, after a most careful search. I do not of course claim any originality for the above suggestion, it being the general practice of surgeons at the present, but wish to call the attention of the general practitioners to it, and divert him from the older methods.

1431 Linden Ave.

*Read before the Medical and Surgical Society of Baltimore, January 12, 1893.

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BALTIMORE, APRIL 15, 1893.

Editorial.

CIVIC CENTRES.

That something is wanting in the management of our great cities is almost self-evident. The red-hot reformer (generally one of tender years) is fully convinced that the thing needed is higher ideals in the governing circles; or even the substitution of new bodies of philanthropic character for the existing civil powers.

But a little experience shows that enthusiasm is not equal to the solution of the problem. Feminine crusades for the besieging of obnoxious saloons have not ended the curse of inebriety. Free soup-houses have not begotten in the tramp a desire for manual labor. Or, to come nearer home, newspaper editorials have not secured for this city clean streets.

Something more is needed, if existing laws are to be more strictly enforced and new laws are to be secured. As matters now stand, the "spoils" politician, backed up by the well-organized powers for evil, laughs at the very spasmodic and "unpractical" efforts of the reformer; while the better class of city rulers have no confidence in the ability of the reformers to "back them up" if enterprises for improvement are undertaken by them.

What is needed seems to be a well-organized union of all the forces in the community that make for good, without distinction of sect, race, or party preference. Such an organization it is believed would, if wisely conducted, wield an enormous power for good in the city; not only in commanding the respect of political "workers," but in supporting the city authorities in every commendable enterprise. Organizations of this nature have been recently established in certain cities of England, and have been recommended in this country.

It is with pleasure that we learn that a movement embracing to a greater or less degree the objects above mentioned has been instituted in Baltimore. A pioneer meeting is to be held in the Y. M. C. A. building on the evening of

April 10th; and doubtless, before reading this editorial, its proceedings and plans will have been learned through the daily press.

We feel it a privilege to call attention to the matter, and to bespeak the interest of the medical public in the movement.

THE STATE BOARD OF HEALTH.

The Profession of Maryland is deeply interested in the expected appointment by the Governor of a new member of the State Board of Health to succeed Dr. Chancellor. It is to be hoped that the appointee will not be too old, and will be thoroughly acquainted with the recent advances in hygiene and public sanitation. The cholera crisis expected during the coming summer and autumn demands that political "influoence" be subordinated to actual fitness in this appointment.

What a capable Board of Health can do is shown by the world-famed records of the Illinois State Board of Health.

Reviews, Books and Pamphlets.

The Disease of Inebriety from Alcohol, Opium and other Narcotic Drugs. Its Etiology, Pathology, Treatment and Medico-Legal Relations. Arranged and compiled by the American Association for the Study and Cure of Inebriety. New York, 1893. E. B. Treat, Publisher, No. 5 Coper Union. Price $2.75.

This volume has been prepared by instruction of the Association, and is intended to represent the work of the Association and the discussions and papers which have appeared in its organ, the Journal of Inebriety, during the last sixteen years.

We find its pages full of information concerning the history of inebriety, and of its legal relations to the State; the nature and treatment of the alcohol craze; with chapters on opium, ether, cocaine, chloroform, coffee and tea, nicotine, cologne, arsenic and ginger habits.

The volume may be considered an authoritative exposition of the views of those who consider these habits to be invariably the manifestations of disease of the brain and nervous system.

Even to those who consider that this view fails to embrace the whole subject, in all its phases, and in every case, the book will still be full of interest from a historical and statistical standpoint, and as a partial survey of the above mentioned drug-habits and their treatment.

The Diseases of the Nervous System; A Text-Book for Physicians and Students; by Dr. Ludwig Hirt, Professor at University of Breslau. Translated with permission of the author by August Hoch, M. D., assisted by Frank R. Smith, M. D., Assistant Physicians to Johns Hopkins Hospital; with an introduction by Wm. Osler, M. D., F.R.C.P., Professor of Medicine in the Johns Hopkins Hospital. With 178 illustrations. New York, 1893: D. Appleton & Co. 8vo., pages 683. Price $5.

The profession owes the English translation of this book to Dr. Osler, who states in the preface that the German edition was recommended to his attention by Dr. Weir Mitchell.

Dr. Osler takes, in his preface, the ground that narrowness of view among Americans upon medical subjects is best counteracted by a knowledge of the work which foreign master-thinkers have given to the world.

Dr. Hirt's book is recommended as the exponent of moderate therapeutic views concerning nervous diseases. It lays claim likewise to some peculiar advantages in regard to the classification of these disorders. A thorough estimation of its merits can only be gained by intimate and somewhat prolonged acquaintance with its contents. We place the volume before our readers upon the high recommendations above stated.

The make-up of the book is altogether attractive—handy size, plain type, clear illustrations, full bibliographical tables.

Transactions of the American Orthopedic Association; Sixth session, held in New York City September 20, 21 and 22, 1892. Volume V. Philadelphia: Published by the Association, 1893.

This volume, a handsome illustrated octavo, is well fitted to maintain the high reputation of the Association for thoughtful work.

Our attention has been especially attracted by the address of the President, Dr. Benjamin Lee, of Philadelphia, on the Inflammation of Cartilage; the articles of Dr. Hoadley on the Mechanical Treatment of Pott's Disease, and of Dr. Sherman on a New Peg-Board Device for Holding Club-foot After Operation; and the admirably illustrated paper of Dr. Bradford on the treatment of Resistant Club-foot.

Diseases of the Skin; Their description, pathology, diagnosis and treatment, with special reference to the skin eruptions of children; by H. Radcliffe Crocker, M. D. (Lond.), Physician for Diseases of the Skin, in University College Hospital, etc. Second edition, revised and enlarged; with 92 woodcuts, 8vo., 987 pages. Price $5. Philadelphia, 1893: P. Blakiston, Son & Co., 1012 Walnut St.

We are delighted with this book, and after perusal take pleasure in recommending it as a text-book to students and practitioners. It seems to us destined to take in the schools the place of Duhring, and other well-known and well-thumbed authorities. It is somewhat fuller than the text-book mentioned and breathes a more personal spirit.

We are especially pleased with the confessions of the author in regard to his inability to make definite groups of certain disorders which have always seemed to us to have very indistinct individuality. His therapeutics are more definite and have more the flavor of personal experience than is usual in standard works on the skin; so that we do not lose ourselves so completely in a host of remedies enumerated under compulsion, in a mechanical way, by the writer.

The work seems to us certainly the best for ordinary use that we have seen (although we do not know all that have recently been published) and it is fully up to date. Its form is handy, its type clear, and its illustrations good. The author does not attempt colored plates for diagnostic purposes.

The only criticisms we have to make are that, being based mainly on experiences gained in England, it may not suit American practice as well as the work of an American. We take issue with the author in his statements in regard to the "bactericide" action of iodoform. Modern research tends to prove that iodoform, though a disinfectant, is in itself not a bactericide for ordinary germs.

The author seems to have overlooked the late discussions of the "iodoform question."

This however does not lessen the value of the book to the practioners; and we would advise all to examine it.

Books and Pamphlets Received.

Medical Communications of the Massachusetts Medical Society, Volume XV, No. 3, 1892, Boston. 8vo., paper. Printed by David Clapp & Son, 115 High St., 1892.

This volume contains many valuable articles, among them the Shattuck Lecture on "The Prevention of Disease in Massachusetts; by J. F. Alleyne Adams, M. D., of Pittsfield.

Transactions of the American Dermatological Association, 15th Annual Meeting, New York.

Transactions of the Texas State Medical Association. Twenty-fourth annual session held at Tyler, Texas, April 26 to 28, 1892. Galveston: J. W. Burson Co., publishers, 1892. H. A. West, M. D., Secretary, Galveston, Texas.

A very creditable volume, cloth bound, neatly illustrated with a goodly number of carefully written medical and surgical articles.

The Third Year's Work at the Clinic of Diseases of the Rectum in the New York Post-Graduate Hospital; by CHARLES B. KELSEY, M. D. Reprint from *New York Medical Journal*, February 13, 1893.

Medical Progress.

POLYPUS OF PROSTATIC URETHRA.

At a recent session of the Royal Medical and Chirurgical Society (*British Medical Journal*), Dr. Thomas Bryant, of London, related the case of a gentleman, aged sixty-three, who had suffered six years from hæmaturia, which was at times very profuse. When seen he was collapsed from loss of blood, and suffering from retention of urine with an enormously enlarged prostate. Temporary relief was afforded by catheterism; an exploratory median perineal operation was performed a few days later. At the operation no disease was found in the bladder, nor any enlargement of the vesical lobe of the prostate gland. The gland otherwise was much enlarged, and felt spongy. On a careful exploration of the prostatic portion of the urethra with the finger, a polypus the size of a haricot bean was found attached to the floor of the urethra, with its body projecting forward, and in the upper surface of the urethra was a depression which corresponded with the body of the growth. The polypus was removed with scissors, and the patient sent to bed with a drainage-tube in his bladder. After a somewhat tedious convalescence he recovered, and now, a year and a-half after the operation, he was well, and his prostate had contracted to its normal size. The growth was proved, by microscopical investigation, to be purely prostatic. The author made some comments on the case, which seemed to him to be very unusual. He was unable to point to one like it. He drew attention to the fact that the growth would

never have been discovered if the fashionable suprapubic operation had been performed.

Dr. Reginald Harrison remarked on the necessity, in cases of chronic hæmaturia, of making a physical examination to ascertain the cause, and on the importance of adopting the perineal operation for growths in the prostatic portion of the urethra.

Dr. Hulke pointed out the analogy between the tumor which the author had brought before the Society and polypi in the canal of the cervix of the uterus, which sometimes led to profuse hæmorrhages.

Dr. Warrington Haward had recently removed a polypus, very similar in appearance to that described from just within the bladder of a man, aged fifty, who had suffered from profuse hæmaturia for the last six months. The structure of the growth had not yet been determined. On the wall of the bladder, close to the root of the polypus, there was a slight papillary outgrowth which he had also scraped away. There had been no hæmaturia since the operation.

Dr. Croft pointed out that there were three interesting considerations in the paper: (1) The question of diagnosis—the case was a very rare one, and so it was very difficult to establish any symptoms by which a polypus in this situation could be diagnosed, yet it was very important to be able to settle whether the growth was in the bladder or in front of it, in the urethra; the fact that hæmorrhage had occurred from the urethra irrespective of micturition might help, he thought, to determine that the growth was in the urethra and not in the bladder; (2) that the growth was a myoma extruded from the prostate and exactly like a myoma from the uterus; (3) the contraction of the prostate to its normal size after the removal of the growth.

Dr. Campbell Williams said that in January, 1890, he had been able to diagnose, by means of Leiter's endoscope, a small polypus growing from the prostatic portion of the urethra, which he had removed, *per urethram*, with perfect success.

Dr. Bryant, in reply, considered that exploratory operation was absolutely necessary in his case. The question of the situation of the tumor, whether in the bladder or in the urethra, was important. He stated that the patient had often found, when trying to micturate, that no urine would flow, but that later, after ceasing from the attempt, the water would come away quite freely, and that sometimes he would introduce a soft catheter, which he could do without any difficulty. It was evident that the patient had, by means of the catheter, pushed aside the polypus. The above facts would, he thought, help in determining whether the tumor was in the urethra or in the bladder. He agreed that the spongy condition of the prostate and its contraction subsequent to the operation were very remarkable.

A CASE OF CRANIECTOMY.

The following illustrative case is given by Dr. Perry in the *British Med. Jour.*, March 18:

History.—B. T., aged 3 years and 3 months (a seven months' child,) did well until 2 years of age, when she was weaned, and lost flesh. When 1 year old she had what the mother describes as a "fit," for a quarter of an hour before which the left half of her face was noticed to be bright scarlet in color, and the right quite pallid; the division was extremely well marked straight down the middle line of her face. The fit occurred at 11.30 P. M.; her eyes were fixed, the right side of her face commenced to twitch, then the right hand and arm and

left leg. She was insensible for two hours, the right arm and hand continued twitching for seven hours, and she has not used this limb voluntarily since. The mouth was drawn to the right side, and continued so for one week. The next day she had another seizure, and these attacks continued to the present time. The longest interval between two fits was a fortnight, and the greatest number of fits in any one day was thirty. Before the onset of a fit she is restless, then retches, the head rests on her knees, the right hand is forcibly flexed, mouth drawn to the right, face becomes blue, she clutches the left side of her head with the left hand, pulling her hair.

Family History.—The parents are healthy, with good family histories. The mother has had one miscarriage.

Condition before Operation.—A well-nourished child, unable to walk or speak, appears to hear and see well, but has a vacant and troubled look; never plays with toys. The right upper limb is never used voluntarily, right hand flexed and pronated. Head carried to the left, eyes directed to the right. She stands very feebly with support, but has no idea of walking; feet turned outwards and widely separated. The left leg she lifts up as if taking a step, but the right is dragged on the ground. Patellar reflexes exaggerated. Superficial reflexes less marked on the right side than on the left. Pupils unequal, do not react to light. Margins of optic disc hazy.

Measurements of Head.—From ear to ear over top of head, 23.5 cm., circumference, 38.8 cm. No trace of fontanelles; these were never seen by the mother; she noticed them in her other children. She says that the cranium has always been completely bony.

Operation.—On December 4th, 1892, assisted by Drs. Keyt and Duke, under A. C. E. mixture, I removed a strip of bone from the whole width of the left parietal bone, measuring 7cm. by 2.2 cm., a finger's breadth from the sagittal suture. The stitches and catgut drain were removed on December 8th, when the wound was healed.

Condition after Operation.—Since the operation (now over two months), the patient has immensely improved. She still has occasional fits, but they are very mild and at longer intervals. She has a very good idea of walking and stands alone. She takes a lively interest in everything about her, and has a happy and contented expression. She grasps objects with her right hand and carries her head straight. The parents think she has spoken a few words.

INCREASE OF CANCER.

At a recent session of the Manchester (England) Medical Society (*Brit. Med. Jour.*, February 11), Dr. Roger Williams pointed out that whereas in 1838 cancer caused 2,448 deaths, being 1 in 6,244 of the population, 1 in 140 of the total mortality, or 160 per million living; in 1890 the deaths due to it numbered 19,433, being 1 in 1,480 of the population, 1 in 28 of the total mortality, or 676 per million living. The proportionate mortality now was more than four times what it was half a century ago. Among women of 35 years of age and upwards it had increased from 1 in 91 for the decennial period 1851-60 to 1 in 12 for the period 1887-89. It was caculated that there could not be fewer than 60,000 persons now suffering from cancer in England and Wales, whereas in 1838 the number was about 7,000. No other disease could show anything like such an increase. It seemed certain that, if unchecked, cancer would ere long become one of the commonest diseases in modern communities. The returns for Scotland, Norway, Netherlands, Prussia, United States, New Zealand, Australia, and

most civilized countries where statistical records had been kept, exhibited similar increases. In all these instances the augmented cancer mortality coincided with progressive population, increased national wealth and marked improvement in the general well-being. It was impossible to regard these coincidences otherwise than as the result of cause and effect. It accorded with this view that in Ireland, where converse conditions had prevailed, namely, decrease of population and widespread poverty, the cancer death-rate had been much lower than in either of the sister countries, and it had shown no such increase as the latter, but had often remained stationary or even declined. Attention was also called to the remarkable decline in the death-rate from phthisis and other tuberculous diseases, which had coincided with the great increase in the cancer mortality. This decline was attributed to improved hygienic conditions, the outcome of that augmented prosperity which was also responsible for the increased cancer mortality. From considerations derived from the study of the family history of cancer patients it was concluded that a large proportion of those thus saved from tubercle eventually perished of cancer and insanity, and Mr. Roger Williams thought the increase in the latter diseases had largely been brought about in this way.

SYPHILIS OF BRAIN AND CORD.

In an article in *Brit. Med. Jour.*, February 11, Dr. Bristowe gives the following diagnostic points:

The difficulty of distinguishing between the symptoms produced by syphilitic disease of cerebral arteries, by intracranial gummata, and by syphilitic inflammation of the membranes or substance of the brain, was dwelt upon. Obstruction of vessels from other causes usually produced sudden paralysis, while the growth of a tumor gave signs of more or less duration. But in all the cases of syphilitic obstruction of arteries Dr. Bristowe had seen the onset of symptoms had been gradual; and further, in no inconsiderable number of cases of brain tumor no appreciable symptoms were produced until the patient was suddenly seized with an epileptic fit or some other form of illness. Further, arteritis; gummata, and pachymeningitis were often developed simultaneously. Still, if in the course of vague cerebral symptoms a syphilitic patient had some sudden seizure and remained hemiplegic, the probabilities were in favor of obstruction of vessels; whereas headache, giddiness, vomiting, optic neuritis, mental perversion or failure, and epileptic attacks pointed to gummata or pachymeningitis, and this would be confirmed by evidence of syphilitic disease of the periosteum, of the skull, or of the ears. Further, gummata and pachymeningitis were especially apt to occur at the base, and to implicate cranial nerves. It was necessary to note that such implication occurred progressively. Syphilitic obstruction of vessels was not limited to the middle cerebrals, as embolic for the most part was, but might involve any of the arteries; consequently softening of the pons or crura might occur and a condition of more or less hemiplegia, with implication of many nerves, be produced closely resembling that which was the consequence of basal gummata. Having regard to the mode of invasion, the character and frequency of the epileptic attacks if present, the sudden or gradual onset of hemiplegia, the grouping and evolution of the paralysis of cranial nerves, a reasonably accurate differential diagnosis might be made in many cases. In the majority, however, no such accuracy was attainable. This, fortunately, was not a matter of great importance in treatment.

Syphilitic Affections of Spinal Cord and Nerves.—There was abundant proof that within the spinal canal, as within the skull, syphilitic arteritis, gummata, and syphilitic pachymeningitis were all liable to occur. Cases were quoted in

which the only possible diagnosis was syphilis. Affection of the spinal nerves outside the spinal canal were probably rare; the lecturer was unable to quote one from his own experience. Localized anæsthesia, neuralgia, or paralysis occurring in syphilitic persons, and not due to cerebral disease, might not unreasonably be suspected to be due to degenerative neuritis of syphilitic origin; but Dr. Bristowe was indisposed to accept the view that symmetrical peripheral neuritis in a syphilitic patient was likely to be distinctly syphilitic.

HEART POLYPUS.

At the meeting of the London Pathological Society, February 7, Dr. Voelcker (*British Medical Journal*) exhibited a specimen of this nature. It occurred in a woman, aged 54, who died four days after admission with general œdema, cyanosis, and bronchitis. A systolic murmur was heard at the apex. After death no vegetations or infarcts were found. The right side of the heart was enlarged, the left ventricle hypertrophied, and dilated, and the mitral valve thickened. In the right auricle was a large gelatinous-looking clot attached to the auricular septum, of the form and size of a champagne cork; it exactly fitted the mitral orifice. The clot was neither softened centrally nor calcified; in the deeper part were many new-formed capillaries and all the evidences of "organization." Dr. Delépine had given references to two cases in which such clots were in process of vascularization. The author thought that the clot probably arose on a vegetation at the lower border of the foramen ovale. Osler had recorded two cases in which a mass of recent vegetations was found around the edge of the foramen ovale.

Dr. Morison referred to a similar case that had been observed by Professor Gairdner, of Glasgow.

DIAGNOSIS OF ACID INDIGESTION.

In reviewing the recently issued book of Dr. Herschell, of London, on *Indigestion*, an exchange says: Dr. Herschell expresses himself strongly against the system in vogue on the Continent of washing out the stomach, and chemically examining its contents. He considers that more accurate results can be obtained by close examination of other functions and organs of the body. Thus he states that if it is desired to ascertain if hydrochloric acid is secreted in sufficient quantity in the stomach, the examination of the urine will give the required information. Three hours after breakfast, and from three to five hours after dinner, the urine is found to be alkaline, because the acid is abstracted from the blood to form gastric juice; if, then, the gastric juice is not secreted in sufficient quantity, the urine remains abnormally acid at the conclusion of the digestive process. This fact Dr. Herschell finds to be of great value, since it will show whether an acid dyspepsia depends upon increase of hydrochloric acid secretion in the stomach, or upon organic acids derived from the fermentation of the stomach contents. In the former case the "alkaline tide" will be observed following the meal at the proper time; in the latter, the urine will remain acid. The amount of chlorides present in the urine will also give indications as to the secretion of hydrochloric acid in the stomach; if excessive, the chlorides in the urine diminish in an extraordinary way.

ULCERATION OF THE ARM FOLLOWING VACCINATION IN A CASE OF HEREDITARY SYPHILIS.

At the late meeting of the Pathological Society, of London (*Lancet*), Dr. Wheaton showed a specimen of this kind. The child was born in an infirmary,

and was vaccinated when seven days old. It was well nourished at the time of birth, but the mother stated that it had "snuffles" from the first. No result followed vaccination until the seventh day, when large white blisters appeared at the point of inoculation. Seven days later the blisters burst, leaving three deep ulcers in the skin. Simultaneously with the bursting of the blisters similar ones appeared on the abdomen. The ulcers on the arm continued to enlarge and two of them coalesced, so that there were two circular ulcers on the arm, each larger than half a dollar, when the child was admitted into the hospital, six weeks after vaccination. On admission there was also a general pemphigoid eruption, with desquamation of the cuticle of the hands and feet, fissures of the mouth, and dark-brown stains on various parts of the body. Mercury was at once given and the ulceration of the arm improved rapidly; when the child died four days later one ulcer had nearly healed and the other had become covered with a thick scab. Dr. Wheaton said that the case was clearly one of phagedenic ulceration, following vaccination, in a child suffering from hereditary disease, and in which the vaccination had hurried on the development of the cutaneous eruptions of hereditary syhilis. In cases where primary inoculation had occurred by vaccination the secondary eruption never appeared in less than nine weeks afterward, whereas in the present case it had developed in fourteen days. The presence of hereditary syphilis was a frequent cause of phagedenic ulceration in infants. Any lesion of the skin, such as vaccination, impetigo, or the separation of the umbilical cord, might be followed by this ulceration; and he had seen it occur on the soft palate, accompanying tonsillitis in a syphilitic infant. It was impossible to avoid vaccinating infants who might appear to be quite healthy but were the subjects of hereditary syphilis, and the earlier the vaccination was performed the greater the risk, as in the case described.—*Medical Record.*

CHANGES OF TYPE IN EPIDEMIC DISEASES.

In a recent Milroy Lecture (*Lancet*, March 18), Dr. Whitelegge, of London, gives the following summary of our knowledge upon this important subject:

1. Epidemic prevalence may be brought about either by increased potency of the disease itself or by increased mechanical facilities for diffusion.

2. Epidemics of the latter class, including water epidemics, milk epidemics and, as a rule, seasonal prevalence, are attended with lowered case mortality, because the conditions under which they occur imply a lessened average susceptibility and therefore a less severe average attack.

3. Underlying all great epidemics there is a change of epidemic type, a change in the quality of the disease itself.

4. There is evidence of a like change on a smaller scale in most, if not all, epidemic diseases, the intensity rising and falling at intervals which are necessarily uniform for the same disease and are very different in different diseases.

5. Whether on the larger or smaller scale, the intensification is marked by greater severity of attack, greater power of overcoming comparative insusceptibility, and greater power of epidemic diffusion.

6. Whilst some diseases are capable of rapid or even abrupt changes in intensity, others are not; and this distinction serves to mark off broadly two principal groups, those which are mobile and those which are comparatively constant in type.

7. The first group, that of diseases which are capable of most rapid change in type, includes those which are most nearly allied to saprophytic life, most readily cultivated in artificial media, most dependent upon filth conditions, most able

to infect soil, water, milk and lower animals, most liable to relapses, and least protective.

8. Diseases of this class may be highly modified, and some of them may assume and maintain a form so slight that their true character is unrecognized.

9. Under favorable conditions their intensity may slowly or suddenly increase, giving rise to epidemics of severe type.

10. Amongst diseases of this class an epidemic normally begins and ends with the milder forms, the more severe attacks occurring at the time of greatest prevalence. The prevalence and severity rise and fall together.

11. In the second group, amongst diseases of more fixed character, extreme modification of epidemic type does not occur; but individual attacks may be extremely mild owing to high resistance.

12. Amongst such diseases there is evidence of a rise and fall of intensity if the epidemic course be traced for a term of years, perhaps covering several minor epidemics.

13. In these brief outbursts of diseases of more constant type there is little if any change of intensity comparable to that of the mobile class, the prevalence being determined and controlled mainly by external conditions, but the type being that of the prevailing phase of a broad cycle.

PREMATURE ALOPECIA.

Dr. Geo. T. Elliot (*New York Medical Journal*) says:

Constitutional and systemic conditions may be causative of alopecia præmatura, but only in a great minority of the cases which come under observation.

The overwhelming majority are due to the local processes which are known as pityriasis capitis, alopecia pityrodes, seborrhœa sicca, and the higher grades to which these may progress by increase in the imflammatory symptoms.

All of these severally described forms of disease are merely stages and grades of the process known to-day as the eczema seborrhoicum of Unna.

The proof of this is seen clinically in the progression and transformation of the slighter grades into the higher, the evolution of one stage to another not being exceptional, but almost always the rule in any given case.

Microscopically, it was found that from the lightest to the highest grade the pathological phenomena were represented by degrees of inflammation of the skin, superficially situated in the former, but extending more or less throughout the entire cutis in the latter. As a result of the inflammatory process, there was a hyperformation of horny epidermis.

The sebaceous glands were found unchanged, the diminution in the amount of their secretion being due to mechanical interference to its egress, not to disturbed function.

The source of the squamæ seen in the various stages is the hyperplastic epidermis, not the sebaceous glands.

In consequence of the processes being inflammatory in nature and situated in the cutis and not in the glands, in consequence of the squamæ being epidermic and not glandular in origin, therefore the inclusion of these processes among glandular diseases of the skin and the designation of seborrhœa attached to them are manifestly erroneous.—*American Lancet.*

METRORRHAGIA AND CANCER.

The editor of the *Lancet* writes with force and truth:

It is scarcely possible to insist too strongly on the fact that a certain proportion of women who suffer from losses of blood, or a blood-stained discharge between

the menstrual periods are suffering from cancer of the uterus, and the responsibility rests with those in attendance to make sure, as far as possible, that a case with this symptom is not a case of cancer before proceeding to treat it by simple remedies such as ergot or hamamelis. If this be borne in mind a larger proportion of cases than at present would be seen in time for operative treatment to have a fair chance of success. There are some popular fallacies, as our readers are well aware, prevailing amongst women themselves with regard to this subject. For instance, there is a notion that pain is invariably associated with cancer, and that consequently so long as there is no pain they may safely assume that their ailment, whatever it may be, is not, at all events, cancer. Similarly, even a larger class of patients erroneously fancy they must be the victims of cancer because they suffer pain. The fact of course is that, as regards cancer of the cervix, pain does not generally occur till a late period in the case, when the disease has reached an advanced stage and satisfactory treatment by operation has become impossible. It is true that in cases of primary cancer of the body of the uterus pain is often an early symptom, but, as is well known, in by far the largest number of such cases the disease begins in the cervix, and here what has been said above applies. Another erroneous prevailing impression is that the disease is necessarily one of advanced life. Now, whilst this is so as regards primary cancer of the body of the uterus, it is certainly not so as regards the cervix. We not rarely meet with cases of the latter class between the ages of twenty-five and thirty, and after thirty they become comparatively common. Again, we must not lose sight of the fact that there is not infrequently some misapprehension as to there necessarily being an offensive discharge in cases of cancer. Such a discharge is practically always present sooner or later, but it is usually later; the point to be remembered is that in many early cases of cancer of the uterus the discharge is not at all offensive. This applies to both classes of cases. The absence of an offensive discharge must not for a moment be taken as warranting a conclusion that the patient is not suffering from cancer.

CHLOROBROM IN MENTAL DISEASES.

The excellent results obtained by the judicious use of the solution named "chlorobrom," introduced by Professor Charteris, of Glasgow, for the prevention and alleviation of sea-sickness, have been recently recorded in the medical papers. I have not seen, however, any note of the solution having been used in the treatment of mental and nervous diseases, and as I have prescribed it in suitable cases in this asylum for about a year with results which seem to show that in it we have a valuable addition to our still too short list of really safe and reliable hypnotics I may perhaps be allowed to state my experience very briefly. As a general sedative in various forms of maniacal excitement, in the excitement of general paralysis, and of epilepsy, I have tried chlorobrom without sufficiently encouraging results to warrant perseverance. In such cases, when it is found necessary to use a sedative, I find sulphonal or the bromides (alone or in combination with cannabis indica) much more efficient and equally safe. As a hypnotic, however, in melancholia and allied mental conditions I have found chloroborm reliable, pleasant to take, and free from risk and from disagreeable after-effects. In the threatened melancholia, brain exhaustion, or breakdown so commonly occurring in over-worked and worried business men, insomnia is usually such an obstinate and painful symptom that the use of a hypnotic cannot be avoided. In some cases the drug which has been of late, perhaps, most in favor in paraldehyde, and it is safe, reliable, and seldom followed by unpleasant sensations. It has, however, a most disagreeable taste, which cannot be disguised, and it im-

parts to the breath an enduring and most objectionable odor. Instead of paraldehyde, therefore, I now prescribe an ounce of chlorobrom to be taken an hour before retiring to rest. I find that a sound sleep, lasting from six to eight hours, is almost invariably produced; that it is not followed by sickness, headache, or lassitude next morning; that the stomach and bowels are not deranged; and that there is no impairment of nutrition even when the drug is given regularly for weeks. A patient at present under my care has increased more than a stone in weight whilst taking a regular nightly dose. Another form of mental depression in which I have found chlorobrom valuable is the excited, or motor, variety of melancholia. In cases of this kind paraldehyde is sometimes quite useless; in fact, unless given in large doses it may even increase the excitement. Chlorobrom has no such tendency. It combines the sedative with the purely hypnotic action and acts somewhat like paraldehyde when given along with bromidia, or one of the bromides. An ounce of the solution may be given an hour before bedtime. When the excitement is considerable a larger dose may be required and may be given withour fear—say, an ounce and a half or two ounces. I have never known unpleasant results to follow. In the other forms of melancholia one is not so frequently driven to the use of hypnotics, but in their treatment, also, my experience of chlorobrom has been favorable, and I intend to use it in future as suitable cases present themselves.

As mentioned above, one ounce is a medium hypnotic dose of chlorobrom, representing thirty grains of chloralamid and thirty grains of bromide of potassium. The full effect is generally produced about an hour after administration. It is not objected to by patients and is swallowed without difficulty, its taste and smell being quite pleasant. It this respect it compares most favorably with paraldehyde, and ease of administration is a matter of no small moment when dealing with insane or nervous patients. Chlorobrom has no disagreeable after-effects. It does not interfere with nutrition. It does not interfere with the restoration of the normal sleep habit, and its discontinuance has not been followed, so far as I have observed, by any morbid craving.—Dr. Keay, in *Lancet*, March 18th.

BLACK TONGUE.

The condition in which the dorsum of the tongue is more or less covered by a black patch is not very uncommon, but its etiology is somewhat obscure. It has been called "hyperkeratosis" with the idea that the superficial layer of epithelium becomes hypertrophied, undergoing horny degeneration, with atrophy of some of the cells and a developement of black pigment. Drs. Ciaglinski and Hewelke, writing in the *Kronika Lekarska*, describe a case in which they were able to find a mould in the black patch somewhat resembling mucor rhizopodiformis, which contained black pigment. The case was that of a woman who a fortnight previously had had some kind of a feverish attack—most probably influenza. The tongue looked as if it had been covered with blacking, the discoloration extending as far back as the circumvallate papillæ. By means of borax washes the tongue became clean in a couple of days. Examination showed a black mould which could be well cultivated on bread or on potatoes at the temperature of the room, but which did not grow at 37° C. It was apparently of a harmless character, for it was injected into the veins of rabbits without effect. Drs. Ciaglinski and Hewelke distinguish two kinds of black tongue—the chronic, due to anatomical changes in the epithelial layer, and the acute, which depends upon the presence of a mould. This is harmless apparently to internal organs, as it does not develop at the temperature of the body.—*Ex.*

IODO-GLYCERINE IN SPINA BIFIDA.

At a recent session of the Irish Royal Academy of Medicine, Dr. McCullagh read a paper on a case of spina bifida successfully treated with iodo-glycerine. The child—a male, now five years and two months old—was not brought under notice of Dr. McCullagh until it was ten months old. There was then in the lumbo-sacral region an ovoid tumor four inches long, three broad, and elevated from two inches and a half to three inches over the surface, the long axis of the oval corresponding to the vertical line; it was sessile, translucent, marked with white bands, fibrous in character, coinciding with depressions on the surface of the tumor as if they constricted it. Dr. McCullagh, having determined to operate, selected the operation best known to connexion with the name of Dr. Morton—namely, after the withdrawal of some of the subarachnoid fluid, the injection of a solution of ten grains iodine with thirty grains iodide of potassium in an ounce of glycerine for the purpose of exciting local inflammation. This operation, however, he modified; finding the withdrawal of the fluid was followed by a convulsion, he found that he obtained quite as much flaccidity in the tumor by laying the child on its face, with the hips raised. Next he found that where he had made the injections completely through the coverings of the tumor the effect was either *nil* or only slight circumscribed meningitis; whereas in those injections where penetration was not perfect, as at the margins and the white fibrous bands already mentioned, small patches resembling the islands in skin-grafting were produced. He therefore confined himself to dealing with the bands and the edges of the tumor, with the result that the whole tumor was soon covered. He then ceased the injections and painted the surface over with a double strength solution, with the result that the covering thickened and soon assumed the indurated condition which was present when the members saw the child exhibited. Dr. McCullagh's conclusions were: 1. That the subsequent meningitis developed in many cases treated by iodo-glycerine was due to the intra-saccular injections. 2. That neither they nor the preliminary evacuations of the contained fluid are necessary. 3. That Dr. Morton's method as modified is not only incomparably safer, but gives a result as good as could be hoped for from the most successful plastic operation.—*Lancet.*

"AKINESIA ALGERA."

Under this term Möbius describes an affection of the nervous system characterized by extreme pain upon motion, so that the patient is unable to make any movement whatever. The exact pathological condition which is the cause of this symptom is as yet unknown. It appears only to occur in neurotic individuals, especially in those who are in a bad state of health generally and who are unable to fight against the weakness. The pain is sometimes directly associated with motion, but in other instances follows it, and is experienced not only in the parts of the body which have been moved, but also in other parts, and may finally lead to almost complete loss of motive power, so that the patient is practically paralyzed. In addition to this pain, which is the most prominent symptom, other phenomena characteristic of neurasthenia may develop, but hysterical outbursts have not been observed. Möbius considers that this disturbance may be attributed to inherited degeneration of the nervous system; that, as a rule, it follows upon mental strain in patients prone to neurasthenia; and that it must be regarded as a psychical affection. The condition must, however, be considered as more allied to hysteria than to hypochondriasis.—*Ex.*

HYDROTHERAPY IN THE TREATMENT OF NERVOUS AND MENTAL DISEASES.

Dr. F. Peterson (*American Journal of the Medical Sciences*) says:

1. Cold and warm baths affect the central nervous system in a reflex manner by stimulating the sensory nerves of the skin and the vaso-motor nerves, and thus influencing the cerebral circulation. Cold excites and warmth diminishes irritability when thus applied.

2. Short cold baths, especially when combined with sprinkling, showering, or rubbing, are powerfully stimulating, exhilarating and tonic.

3. Prolonged warm baths, steam and hot-air baths, and the hot pack, are relaxing, fatiguing and soporific.

4. A cold bath stimulates various reflexes in the body, such as peristalsis and the visceral reflexes in the sacral portion of the spinal cord.

5. Warm baths, by soothing peripheral nerve irritability, exert a calmative influence over the central nervous system. They mitigate reflex spasm and contractions in voluntary or involuntary muscle.

6. Cold applications to the skin stimulate vaso-dilator nerves, dilute the peripheral vessels, and increase blood-pressure. Warm applications also dilate superficial capillaries, but by diminishing the tone of the vessel-walls they also reduce arterial tension.

7. To lower the irritability of individual nerves or of the entire nervous system, prolonged warm baths or the hot pack are indicated.

8. As many hydrotherapeutic measures tend to reduce temperature, it is important to remember that in non-febrile cases, in anæmic conditions, and in debilitated states, the temperature must be raised artificially before subjecting patients to hydriatic treatment. In some cases the temperature of the body on rising from bed in the morning is sufficient; in others as a short stay in the hot-box may be needed.—*American Lancet.*

PNEUMONIA WITHOUT COUGH.

A young man, aged twenty-two, contracted the above mentioned disease, which, when I was first sent for, was in the acute inflammatory stage, with high temperature (104°F.) and delirium. The pneumonia ran its usual course of hepatisation and resolution, and all the symptoms—fine crepitation at the base of the lung, tubular breathing, and dulness—were well marked. But one symptom was absent—cough. Each morning when I asked the nurse whether the cough had been troublesome, the answer was that "he had not coughed at all," and as far as I could hear the patient was never troubled in that way all through the illness, except during the primary stage of the delirium, when he kicked about somewhat, and then it was very slight. I could never ascertain that he expectorated more than once or twice after the first stage had passed, and the amount would scarcely fill a thimble. Now, he was a man of a particularly phlegmatic disposition, and during his illness he would lie perfectly still and quiet, never speaking to anyone, and never moving voluntarily, and this I take to be the cause of the lack of a prominent symptom, and it suggests to me that a pneumonic case may be saved a considerable amount of pain and distress by insisting upon absolute prohibition from talking, and the minimum amount of movement.—Robert Aldous, in *British Medical Journal.*

FŒTAL HEAD RETAINED OVER THREE MONTHS IN THE UTERUS.

Dr. Loisnel (*University Medical Magazine*) describes the following case which came under his observation: In November of last year, Dr. Notta was called to attend a woman who had felt labor pains at term three months before. She was

III-para, her previous labors resulting in spontaneous delivery. The doctor attempted turning, and failing in this, he then amputated the leg. On the day following, he cut off the other leg. The next day he decapitated and removed the trunk and arms. Antiseptic injections were prescribed, but, through ignorance of the patient, were not given. The woman resumed her work, but was annoyed by the lochia continuing longer than usual. The doctor found a vesico-uterine fistula and a solid body occupying the uterus. He extracted a piece of maxilla by the aid of forceps. Patient was then admitted to a hospital. The os was dilated and the fœtal skull removed in pieces. There had been to this time no signs of setieæmia. Afterward there was an occasional rise of temperature during recovery. The vesico-uterine fistula closed, but a communication established itself between the rectum and genital tract. Dr. Hergott once extracted the placenta from a woman who had been delivered seven months previously. There had been no septic symptoms. In the discussion, Professor Tarnier remarked that some women resisted septic infection, and others recovered from it. Sloughing of the whole bladder did not always prove fatal. He had seen recovery after diffuse abscesses and suppuration of both eyeballs. Drs. Notta and Loisnel had, in extracting the head piecemeal, done the best possible thing, considering that they had not the choice of many instruments.—*Med. Rec.*

RESPONSIBILITY OF SURGEONS IN USING ANÆSTHETICS.

Dr. Passet (*Münch. Med. Woch.—International Journal of Surgery*) says:

The induction of anæsthesia should be preceded by a careful examination of the patient, especially of his respiratory and circulatory organs.

If chloroform is administered, it should be admixed with a sufficient amount of air.

The anæsthetic should be discontinued as soon as intolerance is established, or disturbances of respiration and circulation occur.

The circulation and respiration should be constantly observed during the narcosis, and disturbances of these functions calmly and vigorously combated by appropriate measures. Even if appearances of death manifest themselves, attempts to revive the patient by artificial respiration and other procedures should be kept up for a sufficient length of time.

No anæsthetic should be administered during the process of gastric digestion. Constricting clothing and artificial teeth should be removed before the induction of anæsthesia.

The anæsthetic should be absolutely pure.—*American Lancet.*

ARSENIC IN CHOREA.

Discussing the uses of arsenic, Dr. William Murray, in the *Lancet* for February 25th, makes a statement that will somewhat surprise American physicians. He says that little stress had been laid on the efficacy of arsenic in large doses in chorea. The use of the drug is a well-established plan of treatment in this country. It is the common teaching that arsenic is of but little value until its physiological effects have been obtained. It is now the universal custom to carry its administration to that point, and even to restrain its action upon the bowels by small doses of opium. The dose should be regulated according to the symptoms and the tolerance of the patient. The author insists upon giving fifteen-drop doses of Fowler's solution for several days; ten drops, he says, will not answer. No fixed rule can be adopted for the use of this or any other drug. It must be administered according to the age and tolerance of the patient. If taken with food in the middle of the meal, it rarely causes digestive disturbance even in very large doses.—*N. Y. Med. Jour.*

THERAPEUTICS OF CHRONIC LEAD POISONING.

Of all the drugs recommended as aids to elimination, potassium iodide has obtained the most favor; nor are observations wanting which seem to warrant this preference. Some of the earlier writers on the subject relied on the fact that cases of chronic lead poisoning improved whilst taking potassium iodide, as constituting proof that it aided elimination. Subsequently isolated analyses of the urine were made after administration of the drug, and considerable amounts of lead were found. Various theories have been formulated to explain the way in which potassium iodide facilitates the elimination of lead. The primitive idea was that lead iodide was formed; this could be supported by experimental evidence. Potassium iodide will attack lead albuminate and insoluble salts like the sulphate, and partially convert them into lead iodide. It was soon seen however that this availed nothing, as lead iodide is a very insoluble salt, so much so that one eminent chemist accounted for the alleged benefit derived from its use in chronic lead poisoning, by stating that it rendered any lead that might be in the system practically insoluble and consequently inert. Then the theory of the formation of a double iodide of lead and potassium was formulated. It is quite true, as is adduced, that double salts like the one named, are as a rule very soluble in water. The difficulty however presents itself that the double iodide of lead and potassium is formed with some difficulty, under conditions which could scarcely be assumed to take place within the organism, and further that it immediately decomposes in the presence of water. Binz's theory as to the action of potassium iodide on albuminous substances has been utilized to explain the action of the drug in liberating the lead from albuminoid combinations. It is assumed that lead when stored up in the tissues exists as an albuminate; that free iodine is evolved from the potassium iodide, which is taken up by the albuminous substances and causes them to undergo rapid metamorphosis, and thus liberates the combined lead. Allowing this, the original difficulty again presents itself; the lead set free would combine with the iodide present in excess, or with the free iodine.

None of these explanations are satisfactory, and I believe for the reason that they attempt to explain a condition that does not exist.

Reference to the tables shows that, when the patients were taking potassium iodide, the amount of lead present in the urine and fæces was not increased. The amounts obtained fluctuated throughout the whole periods of observation, whether potassium iodide was being taken or not; the sole constant feature was a progressive diminution in the total amount of lead daily eliminated. These fluctuations might, in isolated experiments, so correspond to the administration of potassium iodide as to encourage the view that the drug was the cause of increased elimination, which in reality was due to accidental disturbances—or, in other words, to some unknown conditions favoring elimination that existed at the time the observations were made. Experimental evidence that potassium iodide favors the elimination of lead is, so far as I have been able to ascertain, solely founded on chemical observations of the urine; the fæces were neglected. During the four months over which, in the first case, my analyses extended, on only one occasion did I fail to obtain a weighable amount of lead sulphate from the fæces. But on many occasions the urine contained but a trace, and on many others no trace at all. This shows the futility of relying on one or two isolated examinations of the urine only.

It is probable that the results obtained by Annuschat were due to isolated experiments. He took the urine passed by a patient suffering from chronic lead

poisoning for two consecutive periods of three and four days respectively, the amounts being for the first three days 1,050 c. c., and for the following four days 2,300 c. c. In neither of these was lead present. After the patient was put on potassium iodide the urine was similarly collected for two periods of three or four days, amounting respectively to 1,580 c. c. and 2,300 c. c. In the 1,580 c. c. 0.0075 gramme of lead, and in the 2,300 c. c. 0.0143 gramme were obtained. Pouchet states that potassium iodide eliminates lead, but not continuously; that after six or ten days the effect of the drug is exhausted, even when given in increased doses; and that if again administered after an interval of two or three weeks it acts as before. It was for the purpose of testing this that I allowed intervals of from a fortnight to three weeks to elapse between the periods of treatment by potassium iodide. My tables show no increase of lead or resumption of the iodide after an interval of negative treatment.

Baths and massage have been long regarded favorably as promoters of lead elimination; and quite recently a case was recorded in which, after treatment with potassium iodide without a trace of lead being found in the urine, the iodide was stopped and general massage was commenced. The result was extraordinary, inasmuch as 50 milligrammes of lead per week were obtained from the urine. Trial of this method, in conjunction with hot baths, was made in my first case. The result seemed to be favorable in producing an increase in the daily excretion of lead by the fæces, but it was insignificant as compared with the enormous increase above mentioned; in this first case of mine, too, the urine showed a slight increase of lead under the massage and hot baths.—Dr. Mann, *Brit. Med. Jour.* February 25.

Medical Items.

Dr. E. E. Mackenzie, who formerly had his office at 324 W. Biddle Street, has removed to the northwest corner of Biddle and Eutaw Streets.

Our readers will please bear in mind the meeting of the Medical and Chirurgical Faculty of Maryland which meets the fourth Tuesday of April in the hall of the Faculty (April 25).

Obliging Felix.—"Donn' yo' know, Miss Caprin, dat yo' will ruin yo' teeth eatin' dat candy?"

Miss Caprin.—"Is dat so? Denn I will take 'em out."—*Judge.*

An exchange makes a plea for the use of fire-guards (netted wire fire-place screens) in all homes where there are children. The natural desire of the child for too close investigation of the coals, and for tilting over the hot water kettle, would thus be forcibly controlled.

The State Board of Medical Examiners is doing a good work in testing the fitness of the young men whom the colleges are turning out upon the world with beautiful diplomas and an uncertain quantity of "education." We await the results with interest.

In view of the large number of small-pox cases at all times reported from Great Britain, it seems strange that the movement against vaccination, under the leadership of certain enthusiasts for personal liberty, should be so persistent and should gain so many adherents.

By the fractional or interrupted method of sterilising milk is meant the alternate heating and cooling of milk for the purpose of more effectually destroying micro-organisms and their spores, and of effecting such destruction at lower temperatures than that of boiling.

There is such a thing as carrying scientific requirements too far. Thus, it seems somewhat absurd for Baltimore to establish expensive agencies for the repeated examination of the drinking water brought from Lake Roland, when any intelligent citizen may see at a glance that numbers of privies and stables are draining into the lake.

New York and Boston are doing more toward supplying public baths than most other cities. In Boston, these baths, which are under charge of the Board of Health and are open during the four hot months of the year, were used 1,125,836 times the past summer. Of the persons using them, 909,889 were men and boys, 216,947 women and girls.—*Ex.*

Lange (*Nouv. Remèdes*) speaks favorably of the use of alkalies in some obstinate cases of pruritus, in which the urine was loaded with uric acid and urates. Sodium bicarbonate, lithium carbonate, and alkaline waters, were employed with advantage, the pruritus being gradually relieved, after the lapse of a few weeks. —*Hot Springs Journal.*

Man born of woman is of few days and no teeth, and indeed it would be money in his pocket sometimes if he had less of either. As for his days, he wasteth one-third of them, and as for his teeth, he has convulsions when he cuts them, and as the last one comes through, lo! the dentist is twirling the first one out; and the last state of that man's jaw is worse than the first, being full of porcelain and a roof-plate built to hold blackberry seeds.—*Burdette.*

A committee has been formed at Buda-Pesth under the presidency of the burgomaster, Herr Karl Kammermayer, for the arrangement of the programme and the general organization of the next International Congress of Hygiene and Demography which is to be held in the Hungarian capital in 1894. An exhibition of hygiene is to be held in connection with the Congress, and every effort is to be made to have the new hospital buildings and the new water supply system finished before the date of meeting, so that foreign hygienists may have something for their scientific delectation.—*Ex.*

Professor Stellwag von Carion, the distinguished ophthalmologist of Vienna, celebrated his 71st birthday on January 28th, amidst a tempest of congratulations from his brother professors, present and former pupils, and the whole medical profession of Vienna. He responded to an address from the students in his clinic with a short homily on the text, "Senectus ipsa est morbus," concluding, however, by hoping that they might all live to be seventy. Not only the professor's house, but his clinic, was so inundated with bouquets that they resembled a flower garden or the boudoir of a prima donna.—*Ex.*

The Baltimore Medical College Faculty has re-elected Dr. David Streett to be dean for the sixth time. Dr. Charles G. Hill was re-elected president. The dean reported that 331 students were enrolled at the session just closed. According to sections of the country, 317 of the students were thus distributed: New England represented by 43; Northern States, 100; Southern States, 128; Western States, 46; Pennsylvania sent the greatest number, 51; Maryland sent

44. The foreign countries were represented as follows: Asia Minor, 3; Canada, 5; England, France, Ireland, Mexico, Newfoundland and West Indies, 1 each. The growth of the college is said to be extraordinary. For six years past the average increase of students has been 56½ per cent. each year. The degree of excellence attained by the last graduating class had never been excelled by any previous class of the college. The new building, costing $75,000, has been completed, and is a typical one for its purposes.—*Sun.*

The *Sei-I-Kwai* is the medical journal of the Society for the Advancement of Medical Science in Japan. Recent numbers have contained, in addition to Professor Ogota's important paper on Dysentery, noted elsewhere, two articles by Dr. Albert Ashmead: one on the Racial Immunity and Inoculation and Secular Restriction of Certain Diseases to Particular Localities before Commerce Disseminated Them, and the second on Rice Culture in Japan, Mexico, and the United States from the Hygienic Point of View. Interesting extracts from the *Annual Report of Health of the Imperial Navy of Japan* are also given. As English readers may be interested in noting the kind of subjects treated of in the Japanese medical world, we take a few of the titles of the abstracts from Japanese and foreign journals at random: Detection of the Tubercle Bacilli in Milk; Sanitary Condition in Constantinople; Diabetes Mellitus and Lesions of the Pancreas; Rules for the Care of Infants; Gymnastics of the Intestines—Tubal Gestation; Rupture into the Peritoneal Cavity, Abdominal Section, Recovery; Hypodermoklysis.—*Ex.*

The hand is one of the most specialized parts in our species. As men are known by their faces, so are they known by their hands. Mr. Galton goes further; he sees a portrait in the papillary ridges, so prominent on the skin of the ungual phalanx. He goes yet further, for the object of his book is to show that these ridges have the unique merit of retaining all their peculiarities unchanged throughout life, and afford in consequence an incomparably surer criterion of indentity than any other bodily feature. He maintains that they may be made to throw welcome light on heredity, symmetry, correlation, and the nature of genera and species. The supposition that the courses of the ridges are wholly determined by the flexures is untenable. Dr. Kollmann conceives that the ridges are formed by lateral pressure between nascent structures. The papillary ridges are said to be first discernible in the fourth month of fœtal life. They grow simultaneously with the general growth of the body, and continue to be sharply defined until old age has set in, when an incipient disintegration of the texture of the skin spoils and may largely obliterate them. Mr. Galton finds that the pattern in every distinct finger print, even though it be only a dabbed impression, contains on a rough average thirty-five different points of reference, in addition to its general peculiarities of outline and core. He had contrived a methodical system of indexing the "arches," "loops" and "whorls" seen on the finger prints of different persons. The ridges require careful following up, every print being thoroughly examined in detail. First of all, the print must be made. Purkinje, seventy years ago, was the first to study finger prints systematically. Mr. Galton gives the most minute directions for procuring correct prints. The bulbs of the fingers and thumbs are pressed on an inked slab and afterwards laid flat on a card. Many precautions are requisite.

Identification is the chief practical use to which Mr. Galton would apply the study of finger marks.—*Ex.*

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HYPODERMATIC MEDICATION IN SYPHILIS.*

BY L. WOLFF, M. D.,

Clinical Professor of Medicine, Woman's Medical College of Pennsylvania; Physician to the German Hospital of Philadelphia; Demonstrator of Chemistry, Jefferson Medical College, etc.

Amongst the therapeutic methods which are largely employed on the continent of Europe, but have found very few adherents in this country is, no doubt, the hypodermatic treatment of syphilis. Although proposed and practised in the early part of 1860, it was some time before it was extensively employed, even abroad. This was, no doubt, largely due to the fact that it was little understood, that, from timidity, the doses employed were by far too small, and results, therefore, not brilliant, as well as from fear of the formation of abscesses and the necessary amount of pain accompanying such medication. The pain accompanying it is to-day still an argument against its employment that is not to be overcome. If we, however, consider that in the principal medical centres of continental Europe little or almost no mercury is given internally any more, even the pain accompanying and following the injections must be outweighed by the results. While the first experiments on hypodermatic medication in syphilis were made with solutions of corrosive sublimate, the insoluble mercurials were soon

*Read before the Philadelphia County Medical Society, March 8, 1893.

substituted by Scarenzio and others. Therefore, we may divide the mercurials into those preparations which are soluble and those which are insoluble mercurials. It was found that if insoluble mercurials were introduced beneath the skin they were rapidly absorbed, that they were soon found in the urine, and, also, often produced the untoward effects of mercury, besides their characteristic inhibiting and curative influence over the lesions of syphilis.

In a former paper on this subject (*Therapeutic Gazette*, November 15, 1889) I dwelt on the history of this method of medication and gave, also, a synopsis of the literature on the subject. I shall, therefore, in this paper, consider principally my experience with this treatment and with the various agents so employed. During my student days I had the opportunity of watching and practising this method, and I have continued to employ it to this day in a large and varied practice which has brought, perhaps, to me an unusual number of cases of early and secondary syphilis. Though I have again and again abandoned it, owing to the pain it occasioned, I have always had to revert to it in order to satisfy my patients, who, if they had been treated hypodermatically once, and were then treated with mercurials taken by the mouth, would gladly stand the pain of the injections rather than the slow results and the digestive derangement caused by the older methods of medication.

I usually begin the injections of corrosive sublimate in the inter-scapular region on one side and about two inches from the posterior vertebral processes, and continue down the back in the costal interspaces—the injections being about one or one and a half inches apart. The effect of the injections on still open primary sores, on indurated glands, on macular syphilides, and on pharyngeal ulcerations may be said to be almost magical. It is noticeable that within a few days, and usually within one week or ten days, all these signs have disappeared. The same beneficent results may, also, be said to take place in specific iritis and choroiditis, and it is especially in these two affections that I consider the hypodermatic administration of corrosive sublimate, in the doses and manner mentioned, of the greatest value. Papular eruptions do not show the same tendency to disappear rapidly under the hypodermatic treatment, but have usually faded within a few weeks. The effect on luetic fever and nocturnal pains is so marked that with the first or second injection the patient notices a marked improvement. I never use less than a one-fourth grain injection at one time and generally employ a one per cent. solution in distilled water, filling a syringe of twenty-five minims capacity. These injections are continued daily, and during the first week or two patients stand the treatment fairly well. There is rarely, during this period, any evidence of soreness of the mouth or gums, nor is there any intestinal trouble noticeable. After the entire back, on both sides, had been gone over with injections, many of which have left quite sensitive indurations, their repetition in or near the old places proves quite painful, and it is only then that real complaints from patients are heard. Usually after eighteen or twenty injections tumefaction of the gums become marked, and gingivitis is often no-

ticed. The daily injections are then intermitted, and are made at intervals of two, three, or four days, the untoward symptoms rapidly disappearing during such intervals. The total number of injections usually made in any one treatment is about twenty-five, but I have continued them to the number of thirty or thirty-five, when marked pigmentation of the local lesions supervened. A good rule may be to carry on hyper-medication for about two weeks after the total disappearance of all symptoms. It is, of course, understood that during this time the patient is to be supported by a liberal diet, by milk punches, and, when the digestion is impaired, by tonics and quinine. The mouth should be kept scrupulously clean, the teeth being cleansed after each meal and at bedtime with a soft brush dipped in a solution of one drachm of potassium chlorate to six ounces of water, and containing, also, a drop of carbolic acid to each fluid ounce. While warm full baths or steam and hot-air baths are adjuvants to the treatment the cold baths should be interdicted, as well as exposure to cold and deprivations. I may safely say that I have made thousands of these injections, and have yet to record a case where they have been followed by abscess or sloughing. All of my cases so treated were ambulant, and I do not remember that any of them have lost a day from their usual vocations.

The immediate effects of the injections of corrosive sublimate have been so uniformly good that I need to consider now only the remote effects on the progress of the disease and its liability to relapses. The permanency of a remedy in syphilis is one of the features of the greatest importance, and here I must say that as rapid as is the beneficial effect of this method of medication, there is a corresponding large number of relapses. Of the cases that I have so treated, and of which I have been able to keep a record, I can safely state that in about sixty per cent. no further symptoms developed. I have notes on a number of cases so treated who subsequently married and raised apparently healthy children. Of the remaining forty per cent., however, I can not say they have done so well, and many of them after receiving two, three, and even four courses of treatment by injections had to submit to treatment by systematic inunction before the tendency to relapse has been overcome.

It is this tendency to relapses which has caused me to abandon hypodermatic injections after a second failure as to permanency of cure. It made me investigate the many other mercurials suitable for hypodermatic medication. It has been experimentally proven by Vajda, of Vienna ("Ueber den Einfluss des Quecksilbers auf den syphilitischen process"), that the iodides inhibited the elimination of mercury by the kidneys, and that the slower the elimination the greater the safety from relapses. For this reason it has been my practice to give five to ten grains of potassium iodide three times daily, after the injection treatment, for months to come; but even this plan has not always prevented frequent relapses. Acting on this indication, and at the suggestion of my friend, Dr. Thomas H. Fenton, I have tried injections of iodo-hydrargyrate of potassium, a compound of iodine and mercury, but I have found these injections no less pain-

ful, and their permanency has not been greater in my hands than with the corrosive sublimate treatment. In respect to permanency, it is said that the injections of the insoluble mercurials are of greater benefit than the soluble ones. This might be inferred from the fact that their conversion into a soluble compound beneath the skin is a slower process, and while thus a mild continued mercurialization is produced the injections need not be repeated so often. The insoluble mercurials have, however, the disadvantage of not being always aseptic, nor of being readily rendered so. It is true that with the introduction of vaseline oil as a vehicle for their hypodermatic administration they can be rendered both less septic as well as less painful.

At the head of the insoluble preparations, so far as efficiency is concerned, calomel must figure. I give below the formula for its use, as well as the formulæ for the other insoluble mercurials, according to Professor Edward Lang in his "Ordinations Formeln:"

℞.—Calomel, Vaseline oil . . . . . aa 4.5 grammes.
Lanolin . . . . . 4 "

Each c.cm. contains 0.371 grammes of mercury, 0.1 c.cm. to be injected not oftener than two or three times the first week.

The precipitated mercuric oxide (hydrarg. oxid. flav.) comes next.

℞.—Yellow oxide of mercury . . . . . 4 grammes.
Vaseline oil . . . . . 4.5 "
Lanolin . . . . . 3.5 "

Each c.cm. contains 0.391 grammes of mercury. To be used as the calomel injection.

The salicylate of mercury is lauded very highly, and is prepared for injection as follows:

℞.—Salicylate of mercury . . . 7 grammes.
Vaseline oil . . . . . 4 "
Lanolin . . . . . 2 "

Each c.cm. contains 0.391 grammes of mercury.

The latest preparation and, at the present time, the one generally employed in the hospitals of Paris, even by the veteran Fournier, is the mercurous oxide, which is really a mercurous-mercuric oxide, but better known as the black oxide of mercury. It is used as per following formula:

℞.—Black oxide of mercury . . 4.7 grammes.
Vaseline oil . . . . . 6.2 "
Lanolin . . . . . 3.1 "

Each c.cm. containing 0.39 grammes of mercury, and to be used as the other preparations.

I might go on and quote in the same manner the thymol-acetate, the diphenylate, and the sozoiodolate of mercury and other forms of the drug, but, as those named are the preparations generally used, I will omit the others.

It will appear from the above that, after all, the virtues of the preparations quoted consist in the amount of mercury they contain and in the slowness of its conversion beneath the skin. The more rapidly converted the sooner the lesions disappear, the more mercury introduced with safety to the general health the greater the curative effect on syphilis; but the slower and more persistent the conversion the greater the permanency of the treatment and the likelihood of a total extinction of the syphilitic poison. It may be said against these insoluble mercurials, and with some force, that their advantage over the soluble preparations is only by their slower action, while the marked local reaction which they produce is quite as much as with the soluble mercurials. Such is really the case, and the desideratum, therefore, seems to be to employ a preparation that will produce the least reaction and that will be slowly converted, while least in its probability to produce untoward effects. Profesor Edward Lang, of Vienna, some years ago experimented on the direct introduction of metallic mercury in minute subdivision as being nearest to the ideal method of inunctions, which yet hold the highest place in permanency in the treatment of syphilis. He found that they were readily borne, and they produced little or no local reaction, and, on account of the slow conversion of the mercury, needed repetition only at long intervals. He claimed that the introduction of the metallic mercury hypodermatically exercised an influence over the syphilitic process which was in direct proportion to its conversion, which could be studied by its excretion through the kidneys. This appealed to me as one of the methods most likely to prove more permanent than any of the others, and I introduced it in my private practice as well as in the wards of the German Hospital under my control.

To fully describe this method I must mention the manner of its preparation for hypodermatic use, as given by Professor Lang in his "Ordinations Formeln." This consists in first making an ointment of mercury with lanolin, as follows:

Anhydric lanolin, 15 grammes; dissolve in q. s. chloroform, 50 grammes, and evaporate the chloroform by continued stirring until the weight is 30 grammes, then add pure metallic mercury, 30 grammes; and continue stirring until all the chloroform is evaporated and the mercury is perfectly extinguished. (This can be recognized, if, by spreading with a spatula on paper, no mercury globules are visible by means of a magnifying glass.)

This is his strong lanolin mercurial ointment, and it forms the basis for his oleum cinereum or gray oil. Of the latter he has two preparations, according to the dilutions, the 50 per cent. and the 30 per cent. oil. The formula for the former is as follows:

℞.—Strong lanolin mercurial ointment . . 9 grammes.
Olive, almond, or vaseline oil . . . 3 grammes.

Mix well.

This contains in each 0.05 c.cm. to 0.04 c.cm. of mercury. 0.05 c.cm. is the average dose for injections, but if desirable to inject double the quantity it is best done in two different places. To produce a very active effect it is advisable to inject twice

a week 0.05 c.cm. of this strong oil until all symptoms have disappeared. After that, and to prevent relapses, 0.05 c.cm. should be injected about once a week or once in two weeks for some time afterward. All injections should be made, beneath the skin, in the back, about one inch from the median line, the semi-solid mixture being previously warmed by immersion in hot water until it becomes fluid. Lang also makes use of injections of 0.05 c.cm., two to four times during the first week, and subsequently every week, and later every two weeks, the same amount. He also recommends a milder gray oil, made as follows from the strong lanolin mercurial ointment:

℞.—Strong lanolin mercurial ointment . . 4.5 grammes.
Oil of sweet almonds (or olive or vaseline oil) 5.5 " —M.

Each c.cm. of this contains 0.366 grammes of mercury. This is termed the 30 per cent. gray oil. Of this oil one-tenth c.cm. is the average injection made in two places of the back.

These formulæ, complicated as they may seem, can be easily worked out, and when once the lanolin mercurial ointment is made the dilution requires very little time, as but small quantities are required; a half ounce will last for weeks and, if necessary, should be made fresh every month or two, although these oils really keep a much longer period.

The syringe for injections should be accurately gauged and subdivided into 0.1 c.cm. and tenth parts thereof. The syringes, as made by Reiner, also Leiter, of Vienna, are used for that purpose, the total capacity of each being a half of a cubic centimetre. They have been accurately gauged, and a certificate of accuracy accompanies each. While it might be well to disinfect the needles and syringe before using, by syringing them with a 4 per cent. carbolic water, I have found that there is but little danger in private practice even if this precaution is not observed. The gluteal regions are said not to be very suitable for these injections.

In the use of the gray oil it has been my practice to inject 0.1 c.cm. every week for the first four to six weeks. Usually macular eruptions fade after the second or third injection, papular ones after the fourth or fifth. Examination of the urine showed the presence of mercury within the first week, and its presence was noted for a month and more after all injections had been stopped. The injections of smaller quantities (0.1 c.cm. of the thirty per cent. oil) in different parts of the back are of greater advantage than the injection of double the amount in one place, the urine showing the mercury sooner in the first case than in the second. The only precaution to be observed in the employment of the gray oil is not to use too much. It is a frequent temptation when the curative process is slow to increase the amount injected or to repeat it oftener. This is to be avoided, as the mercury is only slowly converted and accumulates to the point when it manifests its potency over the syphilitic process. Another precaution to be observed is to pay careful attention to the teeth and mouth. As the development of absorbable mercurial compounds is progressive the injections

should be discontinued or made less; even upon the slightest effect noticed on the gums. This medication is a most effective and potent one, and I can readily see how, by a lack of precaution, severe salivation might ensue. Let no one suppose that, as there is little reaction immediately upon the injection, it might be pushed without hesitation. The literature has several cases where an uncalled-for free use of this remedy has caused not only bad but also fatal results. In my experience such has not been the case, although I have employed it with uniformly happy results in a large number of cases.

To sum up the indications for the hypodermatic medication of syphilis, I should say that in cases where the symptoms require urgency of treatment I would employ the injection of a one-fourth grain of corrosive sublimate, at first daily and subsequently every other day until about twenty-five injections have been given. If, after this, all the symptoms have not entirely subsided (entire absence of all pigmentation) I should resort to injections of the 30 per cent. gray oil, 0.1 c.cm. in one or two places in the back once a week until six or eight injections have been made. If, after a shorter or longer period without medication, further manifestations of syphilis should appear, the same series of injections with gray oil should be made and thus continued until, after long lapses between treatment, no further return of the lesions appears. The injections of corrosive sublimate, as described, have the advantage of more rapid action, and will often suffice. I should always recommend their use at first as preferable to others, but when relapses occur the injections of gray oil are less painful and promise greater immunity from subsequent relapses.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEELING HELD MARCH 3, 1893.

The 277th regular meeting was called to order by the President, Dr. William E. Moseley.

Dr. J. W. Chambers exhibited a patient upon whom he had operated in November, 1892, for injury caused by gun-shot wound. The upper portion of the humerus and the lower end of the ulna were resected and two fingers were amputated. About six inches of the upper end of the humerus were removed and three inches of the lower end of the ulna. It was a question of amputation or resection. Dr. Chambers thinks that most any condition of an arm is preferable to no arm. An arm is worth something for appearance sake even if it is not useful, and it helps to keep away the curve of the spine which occurs after loss of an arm. From the statistics obtained during the civil war it would appear that there is somewhat greater danger from resection than from amputation. In six cases resected by Dr. Chambers there has been one death. This death occurred in a man of seventy, who died of pneumonia not long after the operation. Recently five primary cases have been reported without a death. With the present methods resection will probably give as good or better results than amputations. This is so with the thigh and there is no reason why it should not be with the

humerus. It is usually stated that when we remove more than four inches of the humerus we cannot expect a very useful arm. There is one case, however, reported in which six inches were removed and the man had a useful arm and could lift two hundred pounds.

Regarding resection of the ulna: The text-books state where you have a gunshot wound or severe injury to the lower end of either radius or ulna, it is better to amputate, or to resect an equal portion of both, or otherwise you will have the hand left in a distorted position. The two cases shown by Dr. Chambers, show that this is not necessarily the case because in neither of them is there any twisting or turning.

Dr. Joseph H. Branham said that these two cases illustrate very forcibly that under modern antiseptic methods limbs can be saved which a short time ago would have been amputated without any hesitation. It would seem that, unless there is some injury besides that to the bone and shoulder, which makes amputation necessary, with antiseptic precautions, the results will be just as good in the partial excision of the upper end of the humerus as in amputation at the shoulder joint. Of course, if there is injury to the more important vessels then the excision would be improper and bad results might follow. Dr. Branham had treated a case somewhat similar to the one exhibited by Dr. Chambers. He saw him two weeks after the accident. The head of the humerus was destroyed and the fragments of bone that were loose were picked out with forceps. An abscess afterwards developed which opened up the axillary regions very extensively. This was drained with a tube and irrigated. The boy made an excellent recovery and now has a good position as a clerk in a railroad office. Not much deformity has resulted.

Dr. J. H. Branham read a paper on EXCISION OF THE PILE-BEARING MEMBRANE FOR HÆMORRHOIDS. (WHITEHEAD'S OPERATION.)

An advance in the treatment of hæmorrhoids was undoubtedly made in 1886 when Whitehead reported his method of total excision of the pile-bearing membrane to the British Medical Society. At that time he had operated on three hundred cases with uniformly good results. The cases which should be submitted to this operation are those severe ones in which the disease is extensive, involving the whole circumference of the mucous membrane lining the lower part of the rectum. Dr. Branham has employed the operation for over three years, and while the number of his cases is not large the results have been very satisfactory and he strongly favors the method although it has been condemned by nearly all the prominent rectal specialists. The different steps in the operation were described. A 1-2000 solution of bichloride of mercury is the antiseptic used. The wound is closed by a continuous catgut suture carried through the skin and the tissues at the bottom of the wound and through the severed mucous membrane. Dr. Branham's cases numbered 15. In no instance has the hæmorrhage been severe and in none has there been secondary hæmorrhage. No abscess or septic infection occurred in these cases. Union was primary in most of the cases, but a slight suppuration occurred in several instances. The advantages of this operation over other operations, especially the ligature and the clamp and cautery, are, that the ligature leaves the wound open to granulate and is more liable to infection and secondary hæmorrhage, is less thorough and is apt to be followed by a return. The clamp and cautery, while leaving the wound at first aseptic, is followed by a large granulation and consequently is more liable to cause contraction with symptoms of stricture.

Dr. S. T. Earle did not think that as a rule rectal specialists condemned the operation. They simply did not recommend it in all cases of hæmorrhoids.

They nearly all speak of it in high terms in cases for which it is especially adapted. Dr. Earle has done the operation repeatedly but only finds it necessary in about one out of six cases. He limits his cases to those where there is a varicose condition of the systemic veins together with internal hæmorrhoids; in this condition no other operation can take its place. He has had in one case, where there was considerable prolapse of the mucous membrane together with the hæmorrhoids, a return of the prolapse in one portion after excision by Whitehead's method. This prolapse was excised and there was no further trouble. Dr. Earle has never met with any hæmorrhage to speak of in this operation and never had any secondary hæmorrhage to occur. This operation is unnecessary in the large majority of cases. Where there are distinct and separate internal hæmorrhoids it is much easier to excise them and the results are just as good.

Dr. Hunter Robb took exception to the use of bichloride of mercury for disinfecting the rectal mucous membrane, and to the use of catgut as a suture material. From the uniformly fatal results produced by corrosive sublimate in irrigating the peritoneal cavity of dogs with solutions of 1-60,000, he is inclined now to hesitate before employing this agent on mucous, serous or incised surfaces. It has been proven that corrosive sublimate in solutions even as weak as 1-60,000 will produce a superficial necrosis of the tissues. and it has also been shown that even in strengths of 1-2,000 or 1-3,000 the drug is not always germicidal in its action. It would not seem advisable therefore to use a substance that causes destruction of the tissues, when in addition there is no certainty that the micro-organisms present will be killed. By producing a necrosis of the tissues the normal resistance of the part would be interfered with and any virulent bacteria that might originally have been present or those that came subsequently in contact with the wounded surface would be much more likely to give rise to an infection of the part. He said that he had repeated with some modifications Dr. Halsted's experiments of irrigating the peritoneal cavity of dogs with bichloride of mercury. He had used 700 c.c. of freshly made aqueous solutions of corrosive sublimate in strengths of 1-40,000 and 1-60,000. Immediately after using one of these solutions the peritoneal cavity was irrigated with the same quantity of sterile warm water, and then sponged as dry as possible. In from twelve hours to four or five days the animals all died.

The lesions found at the autopsy were those produced by the toxic effects of corrosive sublimate. They consisted of marked diphtheritic deposits on the intestinal mucous membrane with intense hyperæmia, particularly in the large intestine and rectum. Although in some instances solutions of bichloride of mercury may be used in the peritoneal cavity without any unfavorable sequel, the results of these experiments with dilute solutions would necessarily lead one to be most careful, since the susceptibility of a given individual to its evil effects can never be predicted.

As to the use of catgut, it seemed to him that it has been clearly proven by the experiments made by Dr. Ghriskey and himself that this substance is a most favorable suture material for micro-organismal invasion, and besides it is impossible to be absolutely sure of sterilizing a cat-gut sufficiently strong to be of use. In their experience silk-worm gut had proven to be the suture material most resistant to bacterial growth, and it has the advantage that it can be easily rendered sterile.

Whitehead's operation for hæmorrhoids is one that he thought it rarely necessary to employ. The operation that he performs is that carried out by Dr. Kelly. The apex of the hæmorrhoid is held with a pair of bullet forceps or by a tenaculum, and an incision made through the superficial layer of tissues encir-

cling its base. A double ligature is passed through the centre of the hæmorrhoid at the base, and each ligature tied separately in the line of incision, one anteriorly and one posteriorly. The portion of the tissues beyond the constriction is then cut off and the pedicle lightly cauterized. A simple sterile protective dressing is applied. This method of operation has given very satisfactory results.

Dr. J. W. Chambers thought that Dr. Branham's cases showed at least that good results can be obtained by Whitehead's operation. He usually does Smith's operation with clamp and cautery. The matter of putting on a ligature and then using a cautery, as described by Dr. Robb, is doing two operations instead of one. The clamp and cautery is unquestionably the best method in simple cases. As to washing out the rectum with bichloride solution, that is hardly as dangerous as Dr. Robb has suggested. It is hard to draw comparisons between the effects of flushing out the peritoneal cavity of a dog and the irrigation of the rectum that has been subject to severe congestions. Of course it is impossible to make the rectum or the mouth perfectly aseptic but there is something about these two localities that makes their tissues unusually resistant to infection and wounds in these regions usually do particularly well.

Dr. W. S. Gardner thought that there was something of a scare about bichloride poisoning. Leopold keeps his sponges in 1-10,000 bichloride and swabs out the abdominal cavity with the solution. During a Cæsarian section he had seen Leopold swab out the uterus and wipe off the outside of that organ with this solution and the patient did perfectly well. Dr. Gardner has a great many times washed out the dilated puerperal uterus with a solution of 1-4000 bichloride with no trouble resulting. Certainly the dilated uterus and vagina offer a very much larger surface for absorption than you can get in the most distended rectum.

Dr. William E. Moseley thought that it was hardly proper to make comparisons between bichloride that is absorbed through the peritoneal membrane into the circulation and then produces lesions in the rectum and the effects due to irrigating the surface of the rectum. He does not use bichloride in the peritoneal cavity but has seen it used repeatedly with no evil results. The method of transfixion as described by Dr. Robb was the oldest one that Dr. Moseley had ever seen or practised. It is a very good method but not new.

Dr. Earle said that he did not hesitate to use bichloride in the rectum but always takes the precaution to wash it out afterward with sterilized water. He had once seen a diarrhœa after the use of bichloride. We cannot expect to make the rectum aseptic but should try to make it as nearly so as possible.

Dr. Branham named Matthews, Kelsey and Allingham as amongst those who condemned the Whitehead operation. As to the use of bichloride, Dr. Robb says that $\frac{1}{8}$ of a grain will kill a dog. Human beings with syphilis take $\frac{1}{8}$ of a grain three or four times a day without any evil results. The perineum is an absorbing membrane and if much bichloride solution is left in it death may result; but the lower portion of the rectum is lined with pavement epithelium and histologically does not differ from skin and there is probably no more likelihood of poisoning from bichloride in applying it to this tissue than in applying it to the skin. This portion of the rectum is an excreting and not an absorbing tissue. As to the use of cat-gut, there seems to be some extra dangers of infection from it. The disadvantage of silk is that it has to be removed and causes some irritation.

Dr. Hunter Robb read a paper on ANÆSTHESIA IN GYNÆCOLOGICAL EXAMINATIONS.

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BALTIMORE, APRIL 22, 1893.

Editorial.

NORTH CAROLINA BOARD OF HEALTH.

The *Bulletin* of this Board for March reports that a new bill relating to the constitution of the Board has been passed. The powers of the Board have been amplified by it, but the hold of the State Medical Society has been weakened. Under the former long-standing laws that Society was accorded the right to elect six of the nine members, the Governor of the State appointing the other three members. Under the new law the Governor gets the right to put in the majority of the commissioners, five, and the Medical Society is cut down to four members. Again, while formerly the Society's appointees held their places for six years, hereafter they must go out at the end of two years, to correspond to the term of office of the Governor's men. This may be good and reasonable legislation, but it has the appearance of an attempted emasculation of the medical interests of the Board by the hands of meddling politicians. If this is the case, the Medical Society seems to owe it to itself to not let the occasion go by without a public protest.

Pan-American Congress.

SECTION ON DISEASES OF CHILDREN.

The organization of this section is complete and the work of arranging a programme is well advanced. Numerous valuable papers have been promised and the success of the meetings is assured. Physicians interested in diseases of children are cordially invited to attend these meetings, which give promise of great interest both to the specialist and general practitioner. Any American physician desiring to read a paper will please communicate at once with the Secretary, who will be pleased to furnish all needed information.

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Reviews, Books and Pamphlets.

Diagnostik und Therapie der Magenkrankheiten nach dem Heutigen Stande der Wissenschaft bearbeitet; von Dr. I. Boas, Specialarzt für Magen und Darmkrankheiten in Berlin. 2 Theil. Spielle Diagnostik und Therapie der Magenkrankheiten. Leipzig: Verlág von George Thieme, 1893.

The volume which lies before us is the second part of the treatise on diseases of the stomach, written by Dr. Boas, the first part of which, on "General Diagnosis and Therapeutics," appeared two years ago. Since the modern methods of research have been developed in the study of diseases of the stomach many new and important insights have been gained into the diagnosis and treatment of these disorders. It is therefore not out of place, at present, to have these newer views collected in book form, and especially by one who has contributed so much to our knowledge of this branch of medicine. Indeed, Dr. Boas has accomplished his task admirably. Each chapter abounds in original and useful information. We may be permitted to call attention to a few of the more important points. In the chapter on chronic gastritis Boas shows how difficult a diagnosis between chronic gastritis and gastric neurosis may become and that even a chemical examination of the gastric juice for hydrochloric acid may leave us in doubt. In these cases then the examination for the enzymes is highly important. Lavage of the stomach is only indicated, where there are products of fermentation formed or where an accumulation of abnormal substances hinders digestion; so that this procedure is limited to cases of chronic gastritis with large collection of mucus, dilatations and cancer. For light forms of ulcer Boas recommends his ambulatory treatment with nitrate of silver solution and to demonstrate its value has produced two instructive curves obtained by means of his algesimeter, showing the disappearance of painful points under this form of treatment. Atony of the stomach is removed from its usual position under nervous disorders and given a place, which its importance deserves among the actual diseases of the stomach. Attention is called to the large quantities of lactic acid formed in cases of cancer as tested with Uffelmann's reagent, which the author considers of high diagnostic importance. To each of the chapters on ulcer, gastrec-

tasia, carcinoma are added the indications for the modern surgical operations with a discussion of the value of the same. At the end of the book are appended diet lists adapted for the treatment of various gastric disorders. These are but a few of the many valuable suggestions of which this book is replete. In conclusion it must be stated that no one who wishes to keep abreast with the modern views in the diagnosis and treatment of diseases of the stomach can afford to be without this book. —Dr. J. Friedenwald.

Medical Progress.

KOUMISS IN OBSTINATE VOMITING.

Numerous cases have been recorded of severe vomiting yielding to koumiss when every other thing has failed, but the beverage is not so much used as it might be.

Case 1. A married woman, age 56, suffered from mitral incompetence with temporary failure of compensation and consequent congestion of the venous systems. She had albuminuria, anasarca of the lower limbs and evidently congestion of the vessels of the stomach, producing extreme retching and vomiting when anything was swallowed. To check this every known remedy was tried without effect. I scarcely exaggerate when I say everything ever suggested was given, from bismuth in its various forms to mineral naphtha, and in the list of dietaries, from brandy and the light wines to soda water. It appeared as if the patient was going to die, apart from other causes, from mere inability to take nourishment, and from exhaustion due to the severe retching when anything was given. At last two tablespoonfuls of koumiss were given and retained, and this dose was repeated every two hours for two days, at which time milk and soda-water was tolerated and the koumiss was left off. The patient ultimately recovered.

Case 2.—A woman, aged 38, in her eighth confinement (under the care of a midwife), on the second day showed distinct signs of that rare disease called by the older writers "proper puerperal fever." The discharge was very fœtid; the belly distended, and so tender she would let nothing touch it; a rash appeared above the pubes; sores appeared on the lips, tongue and in the mouth. The temperature was 103.5° F. and the pulse 130. There were signs of pneumonia. There was fitful diarrhœa and severe vomiting. Everything save the opium mixture she was then having was returned. Koumiss was given, as in case 1, and retained and left off as soon as other food could be taken. After a protracted illness, complicated by abscesses, she got well.

Case 3.—(For notes of this case and permission to publish it, I am indebted to Dr. Bisset Smith.) A married lady of 24, suffering from typhoid fever, had hæmorrhage from the bowel on the seventeenth day, but got over this and did well till 4 30 on the morning of the thirty-seventh day, when she again passed blood to the extent of 15 ounces, with oozing going on all day. She became deadly pale, and at 6 P. M. the same day the temperature fell to 97°, and at 10 P. M., when she was seen by a consultant, the pulse could not be counted at the wrist, and the heart was very feeble and beat 150 a minute. Vomiting now became a prominent symptom. Champagne was tried and likewise brandy and soda water without good results. Black coffee without sugar and bismuth mixture were also given, but unsuccessfully. Ether hypodermically was administered for the collapse, but had no effect on the vomiting. Vomiting continued all night at intervals, and she looked as if sinking. Next morning koumiss was

administered in two-tablepoonsful doses at frequent intervals, with the happiest results. Every two hours she was also given a mixture of ¼ gr. cocaine hydrochlorate and *m*2½ prussic acid. The vomiting ceased entirely and the koumiss was stopped. Strangely enough the patient had a great adversion to the koumiss, and yet it was the only thing retained. Contrary to the expectation of everyone, she made a rapid recovery.

The happy results which I have had with the beverage in question led me to make a detailed examination of it to see if I could find present any form of alcohol or ether or other substance to which it owes its efficacy. The analysis and notes have been published in the *Pharmaceutical Journal* of December 24th. 1892. My observations lead me to believe that it owes its efficacy to the fact that the casein (true) acts as a soft, soothing agent to the irritated gastric mucous membrane, and is not digested till it reaches the duodenum, while the small amount of serum albumin orginally present in the milk is in great part changed into acid albumin and proteoses (albumose), and so easily digested by the stomach. The alcohols (aromatic and others), the aromatic bodies, the carbonic acid gas locked up in the proteids, hence given off in small amount at a time, have all also, no doubt, an anæsthetic and at the same time an agreeable stimulating effect.

Mode of Preparation.—Having had difficulty in getting koumiss in the country when wanted, I took to making it myself, and taught the housemaid, who now makes it for me from the following simple receipt. (It does not seem to be of much importance whether the beverage be one day old or six months. Case 1 was treated by one day old and case 3 by six-month old koumiss.) Into a soda or half-pint beer bottle (strong) put in a bit of German yeast the size of a pea (10 grs.) or half a teaspoonful of brewer's yeast; a 2-drachm boxful of powdered sugar (65 grs.); a 2-drachm cut down boxful of milk sugar (110 grs.); cold water, 4 tablespoonfuls (2 oz.); and well-skimmed milk to come up to the beginning of the neck of the bottle. Cork tightly, shake well, and tie the cork down. Leave in the kitchen for six hours and then transfer to a cool place, and it is ready for use in forty-eight hours; or, if desired earlier, it can be matured in about eighteen hours in the kitchen. The bottles are to kept on their sides. It must be removed from the bottles by means of a tap, the bottle to be shaken up before each portion is drawn off.—Dr. Sharp, *Brit. Medical Journal.*

ENUCLEATION OF THE EYE.

In the *Philadelphia Polyclinic*, April 15th, Dr. Edward Jackson, of Philadelphia, gives the following summary of the indications for enucleation of the eye:

1. The presence in the eye of a malignant new growth, as glioma, sarcoma, or tuberculosis. This indication is imperative, no matter how much vision the eye retains.

2. The presence in the eye of a foreign body, with iridocyclitis. If the injury be recent and the inflammatory process still active, and the patient cannot remain under observation, an eye with anything less than thoroughly useful vision should be sacrificed.

3. The presence of a foreign body in a blind eye.

4. Blindness with diminished tension of the eye-ball, following perforation either by traumatism or corneal ulcer most urgent after traumatic perforation of the exposed portion of the sclera.

5. Blindness the result of irido-chloroiditis without perforation of the eye-ball, if the patient cannot remain under observation.

6. Sympathetic inflammation, provided the exciting eye does not possess vision

sufficiently good to be weighed against the chances of the sympathizing eye.

7. The actual presence of sympathetic irritation; not the risk of it, unless the patient is likely to be out of reach of surgical aid.

8. Persistent pain in a blind eye, sufficient to annoy its possessor or tempt him to the use of analgesic drugs.

9. Serious disfigurement of a blind eye, even if free from pain or risk of causing sympathetic disease.

COCAINE PHENATE.

After relating seven cases in which he had used this new drug, Dr. Veasey (*Medical News*, April 1) says: From the foregoing experiments and cases it seems that the following conclusions are justifiable:

1. In cocaine phenate we have a drug that can be successfully used, without producing systemic effects, in those cases in which there exists an idiosyncrasy to the local use of cocaine hydrochlorate.

2. As good an anæsthetic effect can be produced with cocaine phenate as with cocaine hydrochlorate, but stronger solutions are required to produce the same degree of anæsthesia.

3. The anæsthesia does not come on so quickly with the phenate as with the hydrochlorate, but lasts fully as long, if not longer, than the anæsthesia from the latter.

4. In some cases, though there be no physiologic contra-indication to the use of the hydrochlorate, the phenate is to be preferred on account of its antiseptic properties.

DOES NORMAL URINE CONTAIN SUGAR?

At a recent session of the Royal Medical and Chirurgical Society (*Lancet*), Sir George Johnson communicated a paper by Mr. G. Stillingfleet Johnson on the absence of sugar from normal human urine. Mr. Johnson stated that all the tests for sugar in common use depended upon its reducing action; thus in Fehling's test the quantity of sugar was gauged by the amount of cupric oxide reduced by a known volume of the solution. All human urine—normal as well as pathological—exerted some reducing action upon cupric salts in boiling alkaline solutions. Insufficient familiarity with this fact not infrequently led to the conclusion that sugar was present in a sample of urine simply because a certain amount of cupric oxide had been reduced thereby. Non-saccharine urines of high specific gravity were especially liable to be pronounced saccharine, because such urines, being highly concentrated, were richer than usual in the normal reducing agents. The object of the author of the paper was to indicate the nature of these "normal reducing agents." He agreed with Dr. Pavy in attributing one-fourth of the reducing action of normal human urine to the uric acid which it contained. He was, however, of opinion that normal human urines were absolutely non-saccharine; and in proof of this he described his method of separating the kreatinin of urine from that secretion, which differed from all methods hitherto described in effecting a complete removal of that base from the unconcentrated secretion by fractional precipitation with mercuric chloride. The properties of the kreatinin thus isolated were different from those of any base hitherto described, and this difference was especially remarkable when its reducing action was compared with that of other kreatinins. These differences in properties between bases having the same empirical formula were attributed to differences in atomic arrangement—isomerism. Although the method adopted —precipitation by mercuric chloride—could not remove sugar from solution in

the urine, the filtrate from the mercurial salt of kreatinin was found in normal urines to be destitute of reducing action; and the determination of the quantity of kreatinin present (by weighing its mercury salt), conjoined with a careful estimation of the kreatinin itself, proved that the entire reducing action of a normal urine might be accounted for by the uric acid and kreatinin which it contained, one-fourth of the whole reduction being due to the uric acid, and the remaining three-fourths to the kreatinin. A beautifully crystallized specimen of the reducing kreatinin of urine was exhibited. In confirmation of Mr. Johnson's conclusion that normal human urine was non-saccharine, C. Schwartz has described a very delicate test for sugar which gives negative results with normal human urine. This test was exhibited during the evening. It was performed as follows: The urine was completely precipitated with lead acetate and filtered. The filtrate was rendered alkaline with potash and a solution of phenylhydrazine added. The mixture was well shaken and boiled. An orange color developed, which was followed by an orange precipitate, when excess of acetic acid was added if sugar were present. Schwarz states, and Mr. Johnson had confirmed his statement, that normal urine give a negative result with this test. The conclusion was that sugar was absent from normal urine. Dr. Curnow stated that he had been able, by means of the phenyl-hydrazine test, to detect so small a quantity of sugar as one-tenth of a grain in an ounce of urine. The test was, he thought, sufficiently simple to be used for clinical purposes. He adverted to the peculiar globular form assumed by the particles of the precipitate under high powers of the microscope. He had also added to non-saccharine urine solutions of urate of potassium and of kreatinin in large quantities, and had found that these bodies did not in the slightest degree interfere with the efficiency of the test. It was on this account that he strongly recommended it for ordinary clinical uses.

MR. GLADSTONE'S SPEECH-POWER.

We must leave to politicians the appraisement of Mr. Gladstone's speech on Monday, regarded as a piece of statesmanship, but regarded from a medical or physiological point of view there can be no difference of opinion. The performance must be regarded and must remain not only as historical, but probably as unique in the history of eloquence and of States. Those who were privileged to be amongst the audience will never forget the scene or the speaker. In the crowded chamber, filled with all that was distinguished and influential in British society, his voice was heard for the first hour of the speech with perfect ease; and even when its physical forces began to abate it was still felt as an influence altogether exquisite and refined. No difference of opinion could avail to save the listener from the spell of a voice, always seconded by the choicest amenity of expression, which it may safely be said has no rival in contemporaneous Parliaments. The wonder is doubled by the fact that the speaker is in his eighty-fourth year. Though there was a perceptible falling off in the force and volume of voice as the second hour was reached, the animation of the orator was all intact. His eye, and especially his right hand brought into emphatic contact with the table from time to time, testified to the vehemence of his thought and feeling, and when occasion required it, as for the delivery of a passage of special importance or for the final peroration, a reserve of voice was again and again drawn upon, and the enthusiasm of the mighty audience swelled the effect of the eloquence by which it was itself swayed. The most marvellous part of all was to see the orator after he had resumed his seat looking as serene as if nothing unusual had been done, and to learn that he

went home to dine quietly with his family and to sleep with as little disturbance as if he only had been engaged in the most ordinary occupation. The record of eloquence is beaten by our octogenarian Premier, and, apart from any consideration of politics, with which we are not concerned, we are all very proud of him.—*Lancet.*

MITRAL REGURGITATION.

In an elaborate article touching the treatment of chronic valvular disease of the heart, Dr. James Tyson, of Philadelphia, writes (*Therapeutic Gazette,* April 18):

The engorgement of the lungs is also relieved by the use of purgatives; and as the portal area, including the liver itself and the stomach, is especially indicated, five to ten grains of blue mass at bedtime, followed by a saline in the morning, relieve the congestion, and with it the nausea and indisposition to take food which attend it. Such remedies may be resorted to semi-occasionally. Sometimes the continuous use of small doses for a long time—say ½ to 1 grain of blue mass thrice daily—are more efficient. The old-fashioned combination of calomel, squills, and digitalis—in doses one-half grain of the first and one grain of the second and third three times a day, or smaller doses more frequently repeated—is sometimes most happy in its effect. Digitalis is a remedy always better intermitted to obtain its effects, and a remedy, too, which, having once excited nausea, is thereafter badly borne. It does, however, sometimes happen that digitalis may be given continuously in moderate doses—say five minims three times a day—with great advantage, while its omission is followed by signs of failing compensation. It is generally recognized that digitalis produces also contraction of the arterioles, and that through this, in connection with the forcible systole, the arterial pressure is increased. This effect is desirable and useful in the early stages of mitral regurgitation, before tricuspid regurgitation and dropsy have set in. Later in the disease, however, when dropsy has set in, this effect militates against the diuretic action which is so much needed. How this may be overcome will be mentioned later.

Before leaving the subject of the heart-tonics in mitral regurgitation, it may be worth while to spend a few minutes on that of the relative value of the different preparations of digitalis. While testimony is generally favorable to the infusion as the most efficient remedy, yet, on account of convenience and accessibility, the tincture is mostly used. I have on many occasions reiterated that I was inclined to believe that the greater apparent efficiency of the infusion was partly due to the fact that it was generally given in larger doses. Thus, a tablespoonful, or one-half ounce, is not an infrequent dose of the infusion, while ten minims, or twenty drops, of the tincture and one grain of the powder are not often exceeded. When it is remembered that a half-ounce of the infusion, as made by the U. S. Pharmacopœia, represents nearly three grains of the powder, or twenty minims of the tincture, one may understand why it is more efficient. Recently, however, I have thought the infusion better borne by the stomach than equivalent doses of the tincture. It may be that the cinnamon-water with which it is made has this effect.

Of remedies which may be substituted for digitalis, strophanthus should, perhaps, be first mentioned; not that it is always the best. Great expectations were excited when the results of strophanthus were first published by Fraser. It will be remembered it was reported as having all the effects of digitalis on the left ventricle without the contracting effect on the arterioles. The expectations

entertained were not, however, realized by clinicians, and it soon fell into partial disuse. Recently I have resumed the use of strophanthus in much larger doses, having given as much as ten minims, or twenty drops, every two hours for forty-eight hours, without interruption, and with good results. It is undoubtedly better borne by the stomach than digitalis.

Caffeine is an admirable heart-tonic in mitral regurgitation. I do not give less than three grains at a dose, but seldom give more, every three hours. When caffeine is given in full doses for some time it produces mental symptoms quite characteristic, consisting in hallucinations not unlike those of delirium tremens, the patient imagining there are persons, animals, and other objects about him, and he is sometimes difficult to control. They, however, cease immediately when the drug is discontinued. Another effect of caffeine, which sometimes interferes with its usefulness, is its effect in inducing insomnia.

Sparteine sulphate is another heart-tonic which I have come to value very highly, especially where a diuretic effect is desired. The dose I have come to rely upon, after a good deal of experience, is never less than one-fourth grain, increased to one-half grain, three, four, and five times a day.

ITCHING OF CENTRAL ORIGIN, OR BRAIN ITCH.

Dr. L. Bremer (*Review of Insanity and Nervous Disease*) calls attention to the importance of itching as a symptom of disease of the central nervous system. He has seen more than one neurasthenic person who, when reading, experienced an intense itching in some part of the scalp, by preference on top of the head. Persons afflicted with this troublesome affection are always neurotic or psychopaths. Most of them can, by sheer will power, produce itching in the parts usually and principally attacked by concentrating their attention on those spots. It has been observed that psychical pain occasioned, for instance, by the death of friends, relatives or parents, is attended by localized or general, more or less intense itching. Pruritus is a frequent complication in mental disease, that taxes the ingenuity and, unfortunately, often baffles the efforts to relieve.

The author has often witnessed pruritus accompanying psychoses; principally melancholia. He has also seen two cases in which this symptom preceded the outbreak of the mental trouble and disappeared as suddenly as it had come on with the first manifestation of the mental derangement. In neurasthenia and hysteria, pruritus, local and general, is not unfrequently a troublesome complication. He has also seen pruritus in cases of coarse brain lesions, particularly in one instance of embolism of the right sylvian artery. Many neurasthenics are immediately and sometimes permanently relieved by treatment with bromides (10 to 12 grains) and cannabis ($\frac{1}{4}$ grain of the extract) three times a day, provided that other remedies and precedures usually employed in the treatment of neurasthenia are not neglected.

Of all the remedies recommended for this kind of pruritus, and in fact pruritus of any kind and origin, the warm bath with a handful of wash soda and half a pound of starch to an ordinary bath tub full of warm water seems to act best.—*Phila. Polyclinic.*

NEW METHOD IN OBLIQUE FRACTURE.

At the session of the Medical Society of London, February 13th, Mr. Keetley described an operation for the prevention of shortening and other forms of malunion after fracture, especially oblique fracture of the long bones. It essentially consisted in the insertion of two pins of steel, thickly plated with silver, one

into each fragment of the bone, not too near the fracture. Each pin had an arm at right angles to it. These two arms, lying outside the skin, were lashed together with silver wire after the fracture had been accurately adjusted. No incision was made, each pin being passed in through a simple puncture. The bones were perforated for the pins by Mr. Keetley's patellar bradawl (with a blade three inches and a half long.) Two cases were described and one patient shown. Both had sustained fracture of the femur. In one the previous shortening had amounted to one inch and in the other to over two inches. One patient fell and refractured the bone two months after operation, but without reappearance of the shortening. In this case the pins had been left *in situ* for six weeks. No pain or rise of temperature occurred in either case. Mr. Keetley recommended that the operation should not be resorted to until ten days or a fortnight after fracture, so that there might be time to see what results ordinary modes of treatment were likely to give and also for effused blood to be either absorbed or organized. Of course strict antiseptic precautions should be used, but in an operation which made merely two punctures and required only two or three simple instruments entirely of plated and polished metal, such precautions were exceptionally easy.—*Lancet.*

TREATMENT OF SO-CALLED INGROWING TOE NAIL.

In a recent number of the *Philadelphia Polyclinic* we find the following suggestive article by Dr. John A. Batton, of Uniontown, Pa.

One cannot but think, after careful examination, that the term is a misnomer. On first inspection you see what is apparently a deeply incurved or ingrowing nail; but if you compare it with the fellow of the opposite toe and consider the hypertrophy of the adjacent soft parts you will at once see that it is the hypertrophy and not the nail that causes the deformity.

The disease begins at the margin of the nail as an abrasion of the skin caused, perhaps, by pressure from a tight-fitting shoe. From this focus of inflammation comes the proliferation of cells and the consequent hypertrophy until the whole side and end of the toe is involved in the inflammatory process and is exceedingly painful and tender.

With a knowledge of the value of continuous pressure in the relief of inflammation, especially when it is superficial; witnessing the effect of Martin's bandage on varicose ulcers of the leg, with their consequent induration, first led me to think of the elastic bandage for the removal of the hypertrophied mass overlying the toe nail.

The method I have used for several years is as follows. Dust over the granulations at the bottom of the sulcus with aristol or iodoform and on top of this put a small piece of lint or cotton.

Take a piece of rubber bandage $\frac{1}{2}$ inch wide and 12 to 14 inches long and, if it is the inside of the toe that is affected, carry a bandage over the nail toward the inflamed structure. This, as you will observe, will have a tendency to carry the mass away from the nail. Beginning at the extreme end of the toe, carry the bandage back, with such pressure as the patient can comfortably stand, until the whole area of inflammation is included. Fasten it by means of a light gum band or tapes fastened to the end of the bandage.

The patient is then able to wear his shoe and attend to his ordinary duties.

The bandage can be removed at night and reapplied by the patient himself, if desirable, the first thing in the morning.

At the end of a few days you will notice a marked reduction in the size of the

toe, and at the end of a short period be able to demonstrate for yourself whether an "ingrowing toe-nail", is in reality, an ingrowing toe nail.

WOOD-SORREL FOR CANCER.

Writing to the *Medical News*, April 1st, Dr. Mitchell says:

Twenty-five years ago my father, then a country practitioner in this county, obtained the knowledge of the peculiar caustic properties possessed by the extracts of wood-sorrel from an old gentlemen living a few miles from my home, who prepared and applied it in the treatment of some form of neoplasm about one of his eyes—probably epithelioma of the lid. I remember very distinctly seeing the man in my father's office, and hearing my father relate how the extract of wood-sorrel had cured the old gentlemen's cancer—but the eye was lost, whether from the effects of the caustic or from the carcinoma I cannot say, and in my youthful indifference I did not deem it of sufficient importance to inquire.

But the preparation of the extract was of far greater moment to me, as my father afterward employed it quite extensively in the treatment of epitheliomas, and supplied it to several other practitioners, as there grew to be quite a demand for the drug in our vicinity. As my father would readily pay one dollar per ounce for it, my brother and myself spent many not unpleasant days in the woods gathering the sorrel, beating it to a pulp, and expressing the juice, which we afterwards exposed to the sun in earthen plates (never in pewter), and were thus able to place on the market a fine article of the solid extract that at once netted us one dollar per ounce and depleted the paternal treasury accordingly.

ACTION OF LIGHT ON BACTERIA.

The recent observations made by Koch on the action of direct sunlight is killing the tubercle bacillus, even in the space of a few minutes and regularly in two or three hours; Roux and Yersin's experiments on the action of light on the diphtheria bacillus; Buchner's, Janowski's and Geisler's experiments on the typhoid fever bacillus are all of very great interest, the two latter observers finding that the parts of the solar spectrum and the spectrum of diffused sunlight were far more active in preventing the growth of organisms and determining their death at the violet than at the red end, whilst Geisler has found that similar results might be obtained even when the electric light is used, especially with the violet rays of its spectrum. Of course the more delicate experiments were done, as Tyndall's earlier experiments were by noting the restraining action of light on the development of the various microbes used rather than by determining the actual death of the organism. Another very important point recently demonstrated, but one often hinted at and even noted before, is that observed by Momont, who found that dry anthrax spores might be exposed with impunity to the action of light for a very considerable time, whilst moist spores exposed to sunlight for forty-eight hours in the presence of oxygen were so devitalized that they could not grow at all. Bacilli without spores under similar conditions were deprived of their vegetative activity by exposure to sunlight in from one to two hours or even less, but in the absence of oxygen very long exposure—forty to fifty hours—was not sufficient to prevent them germinating when introduced into a suitable medium.—*Ex.*

The *Brooklyn Medical Journal* gives the following local treatment for colds: When sneezing occurs, before inflammatory action has set in, use the following as a snuff or with insufflator. ℞. Sodii salicyl. ℥ ss.; Acid boraci (pulv.) ℥ j.; cocain. hydrochlor. gr. xxij. Mix by agitation, not in a mortar.

Medical Items.

The Mayor of Baltimore has approved the measure appropriating $45,000 to purchase land and erect a hospital for infectious diseases.

In connection with the well-known fact that babies are often met in our cities starving upon a diet of "condensed milk," it is interesting to learn that the *British Medical Journal*, having had several samples labled "condensed milk" analysed, finds them deficient in fat to the extent of 50, 80 and 90 per cent. respectively, and consequently unfit for food.

The Congress of Medico-Climatology will convene in the Art Building in Chicago, May 29th, continuing one week. A choice programme has been arranged and many of the most noted climatologists have promised to be present. This Congress promises to be one of the most interesting that will meet during the World's Fair year. Thursday, June 1st, has been appointed a Field Day for the discussion of the causative and curative relations of climates to consumption. Reports from all parts of the world will be presented. All physicians are cordially invited to be present. L. B. Hayman, M. D., Secretary, 70 State St.

The 95th Annual Convention of the Medical and Chirurgical Faculty of the State of Maryland will be held in the hall, corner St. Paul and Saratoga Streets, Baltimore, commencing Tuesday, April 25, at 12 M. sharp. Delegates must present their credentials at 11.30 A. M., same day. The President's address by Professor Louis McLane Tiffany, M. D., will be delivered at 12.30 P. M., the first day. The annual oration will be delivered at 8 P. M., Thursday, April 27, by Professor Reginald H. Fitz, M. D., of the Harvard University, on "Intraperitoneal Hæmorrhage." The titles of all papers must be sent to the recording secretary, Dr. G. Lane Taneyhill, 1103 Madison Ave., on or before Wednesday, April 19, otherwise they may fail to be listed on the programme. There will be an extensive pharmaceutical exhibit in the same building. The profession is cordially invited. Louis McLane Tiffany, M. D., President, and James M. Craighill, M. D., Corresponding Secretary.

It is not infrequently the case where small bits of iron or steel have been imbedded in the cornea—especially when they have come from a heated piece of metal—that after their removal the corneal wound shows no tendency to heal rapidly, and that the irritation and discomfort of the wound continue. According to Dr. John Dunn, Chief of Clinic of the Richmond, Va., Eye, Ear, and Throat Infirmary, examination of these wounds with artificial light will most frequently reveal at their bottom what at first sight appears to be small bits of the original foreign body. They are not so, however, but are either small areas representing the action of oxidizing iron on the corneal tissue, or are partly burnt corneal tissue. These small areas act as foreign bodies, and the corneal wound shows little tendency to heal as long as they remain. Often, when the corneal wound is deep, they require considerable skill to detach them. At times they may be scraped away; while in other cases, after detaching them, they have to be cut off with a small pair of scissors. They should be carefully sought for after the extraction of every piece of steel.—*Va. Med. Monthly.*

A special dispatch to the *Baltimore Sun*, from Philadelphia, says a branch of

the Woman's National Health Protective Association just formed in that city is preparing to lead the street-cleaning contractors and policemen an unhappy life. The association intends to get the city in good condition for the reception of cholera. For that purpose missionaries are to work upon housekeepers and a special bureau is to take charge of complaints against street-cleaning contractors. An office has been opened for the filing of these complaints and a committee of energetic women will see that they are promptly attended to. The association has printed a list of the nuisances prohibited by the ordinances and the policemen are to be coerced into an enforcement of the ordinances on that subject. Some of the most energetic women in Philadelphia have taken hold of the matter and the city officials, especially the contractors and inspectors, will find that their lot is not a happy one unless they begin at once to do their full duty. Secret complaints against uncleanly neighbors are also invited. These if well founded will be backed by the association and reforms introduced in houses as well as in the street.

The report of commissioners sent by the London *Lancet*, the leading British medical publication, to Chicago to investigate the character of the water there, has attracted much attention. It is not likely that this report of the deplorable condition of the Chicago water supply will greatly deter Europeans from visiting the Fair. It is not the habit of English, German or French people to drink water as a rule to any great extent. They usually drink light wines or malt liquors instead and those who have any fancy for water will have no difficulty in procuring bottled mineral or table waters of recognized purity.

At first glance it would seem preposterous that Chicago, built upon the banks of one of the great lakes which contain a half of all the fresh water in the world and which is as pure and good as any drinking water need be, should be compelled to submit to polluted water. But the trouble comes from the sewage question, which puzzles Chicago, as it does nearly every other large city in the land. There is at present no place for the discharge of the sewage of the great city except the lake and so the water is first polluted and then distributed through the pipes for the people to drink. The Chicago river, a sluggish stream which flows through the heart of the city, is the main sewer into which the greater portion of the sewage of the city empties. The water which this river discharges into the lake is described by the *Lancet's* commissioners as worse than crude sewage. In addition to this the sewers from a district of the city having a population of 200,000 empty directly into the lake. This polluted water has reached the end of the tunnel, two miles out in the lake, through which the city's water supply has until recently flowed.

With characteristic enterprise the Chicago people went to work some time ago to remedy the trouble, and have just completed, at a large expense, a tunnel reaching out four miles under the lake. Even to this distance, however, the polluted water, according to the Chicago papers, occasionally reaches, and the *Lancet's* commissioners report that there are deposits in the pipes, which pollute the pure water which may flow in. It is expected that before long a remedy will be had in the completion of the canal, which will cause the Chicago river to flow into the Illinois river and so into the Mississippi, in a direction opposite from its present course.

The high death-rate from typhoid fever which has prevailed for several years is now lowered, either in consequence of purer water or of the growing practice of boiling that used for drinking.—*Sun.*